Encountering Client Grief: A Phenomenological Study of Experienced Psychologists

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Abstract

Empirical research across groups of psychotherapists regarding the phenomenon of working with client grief is limited, particularly research into psychologists' experience in this area. This study's inquiry aimed to shed light on the impact that working with issues of grief in this relationship-intensive profession might have on the experienced therapist, and what can be learned from this. This phenomenological study used qualitative methods to examine 12 psychologists' lived experiences of encountering client grief. An in-person, semi-structured interview was conducted with each participant, guided by three research questions: (1) How are experienced psychologists impacted by their recurrent close proximity to client's experiences of grief and loss? (2) How do experienced psychologists time and again open themselves to and engage this affective work with clients? (3) How do experienced psychologists maintain vitality when time and again engaging in this relational work with clients experiencing loss? The data was analyzed using Interpretative Phenomenological Analysis (IPA) methodology. Four superordinate themes were identified, under which 17 themes were organized. Superordinate themes included the following: (1) An expansive understanding of grief, (2) Navigating the intersections of personal and professional experience with grief, (3) Role of therapist in working with grief, and (4) Factors promoting resilience when working with grief. Analysis of participant responses served to illuminate the significance for therapists of encounters with client grief over time in the profession, with impact on therapist self-awareness, resilience, and training. Major findings, study strengths and limitations, recommendations, and implications are discussed.

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Chapter One

Introduction

Therapy is relationship-intensive work, and personal engagement and empathic attunement guide the therapist into an encounter with the human condition. Sometimes grief is the primary concern that brings the client through the door, while other times it is an underlying concern that impacts other presenting issues. Client grief is time and again encountered by therapists in the course of their work. Human experience involves loss and growth—as such, grief eventually touches each life, therapist included.

At the heart of this dissertation study was a qualitative research exploration into therapists' experiences of encountering client grief. As will be seen, this study investigated established psychologists' experiences of working with client concerns of loss and grief over years in the profession. It explored what challenges as well as what gifts such encounters might hold, and what these might mean for the therapists in this study.

In this chapter, the theoretical foundations that inform this study are briefly introduced. A rationale is provided for the research inquiry, which integrates the grief literature and the therapist literature and illuminates the anticipated significance of the study. Finally, the study's purpose and aims are introduced, and definitional constructs for grief and its correlates are offered in order to clarify the scope of the study.

Foundations of the Study

The current study is at once a grief study and a therapist study, and as such is anchored in these two domains of research inquiry. A brief overview of these foundations follow and will be further discussed in the next chapter.

The psychology grief literature. Understanding of grief has shifted and changed over time in the discipline of psychology, especially with regard to how the Western helping professions conceptualize and respond to grief. As one example, early Western wisdom in the field, largely influenced by Freud's perspectives on the subject, suggested that healthy grief meant detaching from or letting go of ties to the deceased (c.f., Hall, 2011). In contrast, current understanding highlights how an ongoing relationship with the deceased—or "continued bonds"—can for many individuals be a healthy and healing response (c.f., Klass, Silverman, and Nickman, 1996). Further, as contemporary studies into the trajectories of grieving highlight various qualitatively distinct paths through grief, there has been a movement in the discipline away from perspectives that may have anticipated—or elevated as healthy—a one-for-all typical trajectory or expression of grief (e.g., Bonanno, 2002). Ongoing grief research explores what nurtures well-being and a greater sense of positive resolution in grief, where possible (Neimeyer & Sands, 2012; Tedeschi & Calhoun, 2004), alongside what fosters complicated, or prolonged, grief (e.g., Prigerson, 2009). For example, particular attention has been given to the place of meaning reconstruction in the wake of major loss, finding it to be significant in bereavement grief outcomes (Neimeyer & Sands, 2012). In light of such ever-evolving

research in the area of grief, the current study investigates the lived experience and role of those who professionally join a grieving individual in times of significant grief.

While the interdisciplinary grief and loss literature is substantial, empirical research related to clinical practice with issues of grief and loss is more limited. Referring to counseling psychology in particular, Servaty-Seib and Taub (2010) note that the field has devoted surprisingly little research attention to topics of grief, loss, and bereavement, pointing to a dearth of relevant articles in the central journals of the discipline. They rightly argue that concerns of grief fit securely into the historical self-understanding of counseling psychology as committed to a life-span, holistic, strengths-focused perspective. "[T]he death of a loved one is arguably one of the quintessential 'problems of living,'" they observe, "an inevitable, universal, and normative human experience" (p. 949). As such, we can expect that individuals who have suffered significant personal loss may seek assistance in navigating this journey. Perhaps the emphasis within counseling psychology over its history on college students has reduced the focus on grief and bereavement.

To be sure, there is a growing body of literature within the discipline of psychology related to interventions and approaches for working with grief (e.g., Neimeyer et al., 2012). However, practitioners' perspective and experience in working with grief, bereavement, and loss have been under-studied. The current study therefore contributes a unique perspective to this literature gap through the voices and experiences of practicing psychologists, as they reflect on their encounters with client grief over time.

While narrower in scope than the grief literature, in part due to the counseling profession's relative youth, research in the area of therapist development has also burgeoned in recent decades. Yet here too, however, the experience of the therapist when working with client grief has received limited attention.

The therapist literature. Psychotherapy is a profoundly human enterprise. Deeply relational work, it requires responsive attending to the experience and emotions of fellow human beings. Empirical research has yielded compelling evidence that the therapeutic relationship is a primary ingredient in terms of the success of therapy, accounting for a significant part of variability in therapy outcome (Duncan et al., 2010). Such research illuminates the significance of a positive therapeutic alliance (Lambert, 2013; Norcross, 2010), underscoring that at its best the therapeutic relationship can foster a "curative relational process" (Skovholt, 2005, p. 85). Beyond the specific strategies therapists employ or the theoretical frameworks to which they ascribe—and in addition to the client's own healing resources and circumstances—the effective therapist can be a prominent factor in therapy outcome (Tracey et al., 2015).

Because of the importance of the therapeutic relationship to the outcomes of therapy, the current study joins a body of research shaped by the conviction that the person and experience of the therapist is a valuable focus of research (Orlinsky & Ronnestad, 2005). It is particularly informed by the literature regarding therapist professional development (Orlinsky & Ronnestad, 2005; Skovholt & Ronnestad, 2013; Jennings & Skovholt, 2016), which illuminates factors that enhance or challenge one's ability to flourish in this helping endeavor over time. Specifically, the current study

examines how experienced psychologists have approached and made personal sense of their work with client grief over the years of clinical practice.

In the therapist literature and research, much attention has been given to the effects of the "wear and tear of emotional giving in one's professional work" in the helping fields (Skovholt & Trotter-Mathison, 2016, p. 30). The range of constructs in the literature illuminates the energy around this topic, as researchers aim to describe the impact of both the debilitating effects of professional stress and energizing components of the work on clinicians in the helping professions. For example, research efforts have examined the interrelated constructs of *burnout* (Freudenberger, 1974), *compassion fatigue* (Figley, 1995), *secondary traumatic stress* (Figley, 1995), and *vicarious trauma* (McCann & Pearlman, 1990). Alongside the research on the deleterious effects of compassion fatigue, there has also been exploration of *compassion satisfaction* (Collins & Long, 2003) as well as the hopeful factors that permit *resilience* of the practitioner in this work (Hou, 2015). There is an experiential spectrum that runs from the problematic experience of depletion to the fullness of professional vitality (Skovholt & Trotter-Mathison, 2016).

In Yalom's (2002) words, the therapist's "most valuable instrument" is the therapist's own self (p. 40). Beyond the techniques and approach utilized, therapists themselves contribute to the therapeutic experience and outcome, including their own personal encounters with grief. The universal nature of grief means there is, from the beginning, an interplay between the personal and professional of the therapist that is particularly salient here.

Significance of the Study

As mobility increases, with many people living far from family or communities of origin, it has become increasingly socially acceptable for persons to seek out professional support when navigating the challenges of life, such as transition, loss, and grief (Worden, 2002). Issues of grief occur across the lifespan, yet with the so-called graying of America, grief related to issues of aging, loss, and end-of-life concerns are increasingly present (Foster and Vacha-Haase, 2013; Dwyer, Deshields, & Nanna, 2012). As persons are disconnected through relocation or through personal change in worldview from traditional sources of support around grief—such as in the form of spiritual leaders, cultural elders, and religious communities—concerns of grief and loss may further make their way into the realm of psychotherapy (Worden, 2002). In short, issues of grief are a universal aspect of human experience and are to be expected within the counseling endeavor. Likewise, as clinicians work with mental health concerns and trauma of their clients, longer-term issues of grief and loss frequently surface as intertwined with the presenting concerns. For these reasons, the therapist's experience of working with grief is deserving of scholarly attention.

Furthermore, informed and thoughtful response to grief in the therapeutic realm is significant because of the impact grief can have on a person's well-being and health. Studies have consistently shown there can be a deleterious impact on mental health, physical health, and even mortality associated with bereavement grief (e.g., Stroebe, Schut, & Stroebe, 2007). To be sure, numerous variables impact such outcomes and resilience is the norm (e.g., Bonanno, 2002, 2004), yet there is increased vulnerability for

negative health outcomes surrounding times of significant loss. In order to provide holistic support, it is important to give research attention to therapists' perspective and response to grief within the therapeutic endeavor, with its significance both for clinicians and the clients they serve.

Psychologist and grief scholar William Worden (2002) writes, "People have been grieving for thousands of years—long before the advent of the mental health professional. Nonetheless, the empirical reality is that people seek us out for help with their grieving" (p. 2). The current study explored this experience of professional accompaniment of others in the age-old and complex phenomenon of grief. This research was done by inviting experienced psychologists to reflect on their work with grieving clients, time and again over their years as practitioners. In so doing, the current study contributes to a literature gap, as the voices and experiences of therapists in general and psychologists in particular have received minimal research attention with regard to the experience of working with client grief. Further, attention to therapists' professional well-being and experience is significant because of its bearing on the relational work they provide, and the potential for professional depletion or professional vitality with regard to this dimension of their work has been noted. A particular emphasis within the inquiry therefore related to the impact of these cumulative experiences on the therapist.

Aims of the study. Within the robust grief and loss literature and substantial literature on therapist factors, surprisingly little empirical attention has been given to therapists' phenomenological experience of working with issues of client grief. One can find many first-person and anecdotal accounts of therapists' experience with specific

personal or professional losses—among these, client suicide, working with bereaved parents, working with the terminally ill. Yet empirical research across groups of therapists regarding this phenomenon is scant, particularly research into psychologists' experience of working with grief. This current study addresses this gap.

This study's inquiry aimed to shed light on the impact that working with issues of grief in this relationship-intensive profession might have on the person of the therapist—whether negative or transformative—and what can be learned from this. Ultimately, any research into therapist development has, by extension, a focus on ethical, informed, professional care for clients. The long-term purpose of the study was to improve therapist competence by helping equip therapists to respond effectively and with care to human grief and suffering, through their encounters with the clients they serve.

This qualitative inquiry into experienced psychologists' encounters with client grief over time in the profession was guided by three primary research questions: (1) How are experienced psychologists impacted by their recurrent close proximity to client's experiences of grief and loss? (2) How do experienced psychologists time and again open themselves to and engage this affective work with clients? And (3) How do experienced psychologists maintain vitality when time and again engaging in this relational work with clients experiencing loss? Analysis of participant responses to these overarching questions was intended to illuminate the significance for therapists of encounters with client grief over time in the profession, with impact for therapist self-awareness, resilience, and training.

Construct Definitions

Some terminology distinctions are offered to clarify the focus and scope of this study.

Grief in Therapy* versus *Grief Therapy. This study focuses on the experience of psychologists working with grieving clients within the realm of therapy. This is not a study of *grief therapy* or *grief counseling*, when these terms are understood to mean a separate form of psychotherapy, adherence to certain grief-focused counseling techniques, or a professional specialty within grief work. That is not the purview of this study, although there are many skillful, research-based techniques and much wisdom for helping professionals to draw on from the grief literature (e.g., Neimeyer et al., 2012). By contrast, this is a study of *grief in therapy*, focused on the experience of practicing psychologists when encountering client grief.

Grief, bereavement, loss. *Grief* is the construct utilized in the current study. It is a broad term that can encapsulate distinction and nuance, including grief specifically related to bereavement loss yet also allowing room for the intangible losses that are part of human experience.

Distinctions in terminology related to the construct of grief are helpful. First, a distinction should be made between *bereavement* and *grief*. Bereavement is the situation of having experienced the death of someone close; it is the fact of the loss. Grief, then, has to do with the response to loss (Zisook & Shear, 2009). Grief can be used to describe "the emotional, cognitive, functional and behavioral responses to the death," and the term can also be "used more broadly to refer to the response to other kinds of loss; people

grieve the loss of their youth, of opportunities, and of functional abilities" (Zisook & Shear, p. 67).

Related terms that might fall under the scope of *grief* are helpful for the current study, as they further explicate the potential nuances and range of loss. For example, Doka (1989) offers the construct of *disenfranchised grief*, which relates to grief that is not acknowledged by society. It is grief for a loss that, for whatever reason, cannot be recognized openly or mourned publicly. Also, Boss (1999) put forward the construct of a*mbiguous loss*, which refers to losses that occur without understanding or closure—whether physical loss and psychological loss. Further, there is the concept of *anticipatory grief*, a term coined by Lindemann (1944), which refers to a grief reaction one might experience in advance of an impending or potential loss.

This study aimed to explore therapists' experience of encountering grief within their clinical work, in whatever way the therapist chose to describe this. As such, the purview of this study was not formally constrained to bereavement grief or a specific type of loss. Selection of the broad term of grief permitted an opening to a fuller discourse about this aspect of the human condition, and aimed not to disenfranchise the grief experiences most salient to the participants' context and experience (Doka, 1989).

Chapter Two

Review of the Literature

This literature review begins with relevant foundations for this study, then narrows to a focus on the study at hand. First, a selection of empirical studies from the broad grief literature are considered, which serve to illuminate current understandings of grief within the discipline of psychology and closely related fields. Second, a different and smaller body of literature is examined, that of the person of the therapist, examined through the lens of therapist development over the course of their profession. A selection of key studies within this domain will be discussed, with particular focus on the experienced therapist. Finally, the focus is further narrowed to a small selection of studies and conceptual articles that integrate these two domains, examining the therapist's experience of working with issues of grief.

Currents in Psychology's Grief Literature

Before exploring what it means for a therapist to encounter a fellow human in their grief, the current understandings of grief within the discipline of psychology and closely related fields are first examined. The grief literature is vast and interdisciplinary in scope, befitting a topic relating to the human condition. Yet scholarly attention within psychology, specifically, continues to deepen and expand our understandings of grief, at times shifting away from earlier strains of thought in the discipline.

Within the research there has been a renewed focus on understanding how people respond differently to significant loss, with an eye toward understanding who might most benefit at times from working with a person in the relationship-intense professions. The

studies that follow investigate correlates to differing grief responses among bereaved adults, which in turn can inform responsive work with clients who have experienced personal loss. The field of thanatology—the study of death and dying—is interdisciplinary and the literature broad. The following set of articles were identified through a review of the psychology literature, specifically, and were selected for this psychological perspective, with first authors all doctoral-level psychologists with a particular research focus on bereavement issues. Further, they were chosen for their representativeness of key areas of focus in the contemporary research literature.

Diverse trajectories of grief, and the role of resilience. First considered is a multifaceted quantitative study conducted by Bonanno and Wortman (2002) that aimed to evaluate divergent patterns of grieving in order to deepen understanding of the sequelae of loss. This study is introduced first, because Bonanno and colleagues' findings both illuminated and challenged prevailing notions of what "common" or "healthy" trajectories of grief look like, often understood to be high initial distress that tapers off over time. Their research utilized data from a large-scale prospective study exploring how older Americans' experience of spousal bereavement influenced their social and psychological adjustment. Bonanno and colleagues focused their inquiry on the experience of 205 individuals who participated in three stages of the study: a baseline assessment plus follow-up at six and eighteen months after their spouse's death.

By examining the prevalence and patterns of symptoms of depression and grief, the researchers analyzed how participants adapted to bereavement over time. They presented these findings: *Chronic grief* (15%) referred to a sustained grief response after

bereavement; *chronic depression* (8%) was indicated by elevated emotional distress before loss and throughout the study; *depressed-improved* (approximately 10%) showed elevated depression scores at baseline, followed by decreased distress (perhaps reflecting, for example, caregiver or marital stress that abated after the partner's death); *resilient* (nearly 46%) was indicated by minimal distress before and after loss; and *common grief* (approximately 11%) was characterized by high initial postloss distress that slowly tapered off (so termed because it has often been considered to be the typical—perhaps even optimal—response). The remaining participants didn't fall into a clear bereavement pattern, although some 4% appeared to have a possible *delayed grief reaction*.

Regarding possible antecedents to divergent grief trajectories, the major finding was that substantial dependency—in terms of high relational or personality dependency—was found to significantly correlate with a chronic grief response. Also, a handful of variables were found to highly correlate with chronic depression. These included participants' low evaluation of their marriage, emotional instability, low self-efficacy in terms of coping ability, and limited sense of agency in life circumstances.

The authors drew upon these findings to challenge some long-held assumptions in the grief literature—assumptions that a healthy bereavement response includes a certain expression of grief, that the absence of overt grief is a sign of suppression or detachment, or that buried grief will emerge in time as a delayed grief reaction. Bonanno and colleagues posited that instead of being problematic, the absence of overt grief may be evidence of resilience and positive adaptation. To further their point, they highlighted that there was no correlation found between the resilient grief pattern and preloss relationship

tensions or personality difficulties. Finally, they note the near absence of a clear delayed grief pattern in their study and question the expectation that a subdued grief response will yield a delayed grief reaction.

While it is compelling to see that the predominant bereavement pattern was the resilient pattern, the findings communicate more about what resilience *is not* than what it *is*. Resilience is here characterized by an absence of key measures of distress; however, this study speaks little to what else characterizes resilience in terms of coping and adaptive qualities. Perhaps one of the key contributions this study makes is that it challenges researchers and practitioners alike to be aware of their assumptions, permitting more nuanced assessment and therapeutic response to persons experiencing bereavement.

In a subsequent study, Bonanno, Moskowitz, and colleagues (2005) sought to further explore the nuances and reach of resilience in bereavement. Whereas a limitation of the 2002 study was that it focused solely on older adults who were conjugally bereaved, the researchers here included a younger demographic and explored two types of bereavement: bereaved parents and partner loss to chronic illness. This 2005 study was a normative comparison between two groups: 64 bereaved and 41 non-bereaved adults in the matched group made up the final study sample.

Analyses revealed two distinct subgroups within the bereaved sample, which the authors termed *resilient* and *symptomatic*. The bereaved group was distinguishable from the matched group at 4-months postloss, but by the 18-month interview, measures no long discriminated between the resilient group and the matched sample. The symptomatic group, by contrast, continued to show marked distress.

Like the earlier findings (Bonanno et al., 2002), resilient functioning was seen in fully half of the participants. No statistical significance emerged between those whose spouse had died versus those whose offspring had died. Significant correlations between friends' report and participant self-report served to corroborate that the resilient group was, indeed, functioning well. In fact, when friends measured the resilient group's typical level of adjustment—that is, their functioning prior to the loss—these individuals were rated at generally better adjustment levels than either the symptomatic bereaved group or the matched group. This suggested that the resilient group possessed particular coping skills and positive traits in their daily life, which may support a resilient response during bereavement. By contrast, friends of the more symptomatic bereaved group noted participants' increased difficulty since loss, observing their overall functioning to be poorer than prior to their loss. This group was struggling in a new way during bereavement.

Prolonged grief as a bereavement response. As noted in Bonanno's work, a majority of bereaved individuals may navigate their loss in adaptive ways, remaining engaged in daily life and functioning well. A sizeable minority of bereaved individuals, however, appear to experience levels of sustained suffering that more fully impact functioning and well-being. Several researchers have trained their focus on this experience—first described as complicated grief and, more recently, as prolonged grief. This topic prompted debate in the field: many argued against pathologizing grief, which is how they interpret such a diagnosis, while others argued that concretizing this diagnosis would permit more focused response and access to care for those who need it.

The two studies next reviewed extend knowledge and understanding of this construct of prolonged grief.

As part of a large-scale research endeavor, Lichtenthal and colleagues (2002) conducted a longitudinal study of 86 bereaved adults who had been primary caregivers for a loved one who died from cancer. Various measures of psychological, physical, and social adaptation were employed, including structured clinical interviews to assess for depression, anxiety, panic, or posttraumatic stress disorder.

Among the salient findings of this study, 16 percent of the sample met criteria for prolonged grief disorder, comparable to other findings in the literature. However, less than half (43%) of these individuals had accessed mental health services in bereavement, despite marked psychological distress. Specifically, participants who had spoken with a provider about emotional distress surrounding their loved one's diagnosis were almost five times more likely to later seek out mental health care during bereavement.

While the study sought to distinguish and clarify a construct of prolonged grief, significant comorbidity was seen with anxiety or depression—suggesting these constructs may not be sufficiently distinguishable. This study extends the conversation about conceptualization of persistent grief, aimed to guide a focused response to those most distressed. Further, by identifying underutilization of mental health services among those with prolonged grief, the study prompts counseling professionals to consider how and what they communicate about grief support to the public and professionals in other disciplines.

A second study of prolonged grief is seen in Boelen's (2012) prospective study utilizing the construct of "centrality of loss." This construct is drawn from posttraumatic stress research and defined as "the extent to which a negative event has become central to one's everyday inferences, life-story, and identity" (p. 117). Boelen here investigated the degree to which the centrality of a loss is associated with the experience of persistent and high distress among a significant minority of grievers.

This was a two-wave prospective study. All participants had experienced loss within the year prior to the first wave of assessment, and a follow-up invitation was sent one year later for the second wave of data collection. While the study was broad in scope, attention is focused here on the comparison of the two waves of data collection (n=100). This is the stronger portion of the study, due to its prospective nature.

A key finding was that centrality of loss was significantly related to symptoms of prolonged grief, depression, and posttraumatic stress over the two waves of this study. The more central the loss continued to be to one's self-concept, the higher were the reported grief symptoms. The prospective design of his study permitted Boelen to assert that his findings revealed centrality of loss to be a significant predictor of continued bereavement-related difficulties. These findings have implications for the practice of counseling and psychotherapy, which can support a strengthened sense of self and shift toward a hopeful future narrative.

The relationship of meaning-making to bereavement adaptation. The following three studies cohere around a shared attention to the role of meaning-making in

bereavement adaptation, an area of inquiry in recent bereavement literature (e.g., Neimeyer & Sands, 2012).

As part of a large multiphase study, Gamino and Sewell (2004) gleaned patterns of meaning-making from qualitative measures, then used quantitative means to assess whether these patterns were predictive of bereavement adjustment. This study was shaped by two overarching research questions: (1) whether there was a difference in bereavement adjustment between participants whose written narratives conveyed elements of hope and recovery and those whose responses were solely expressions of distress, and (2) whether the identified meaning constructs individually correlated with adjustment.

Eighty-five bereaved adults participated in this study. First, participants free-wrote a response to the question "What does the death of your loved one mean to you?" Next, they completed a battery of psychometric assessments exploring affect and adjustment dimensions of grief. Finally, they participated in a semi-structured interview further exploring demographic information and details of the loss.

They found a particularly strong relationship between the *Focusing on Negativity* meaning category and bereavement adjustment. Where this negativity category was prevalent, there was a strong correlation with poorer levels of adjustment, less indication of personal growth, and greater distress symptoms. The interview data was used here to shed some light on this meaning category, such as revealing that participants whose essays focused on negativity were less likely than their counterparts to have experienced a sense of having said goodbye to their loved one.

The integrative design shed light on the fact that some individuals were deeply hurting—seen in the negative valence of their written narratives and in their poor coping on the adjustment measures. The authors suggest that this group is at particular risk for continued difficulty in adjustment and recovery, and may be the group most in need of professional mental health support. Likewise, the integrative design illuminated how some participants found hope and opportunities for growth through their difficult experiences of suffering, which too might inform therapeutic work.

In another study that sought to explore the relationship of meaning-making to the severity of grief, by Keesee, Currier, and Neimeyer (2008) focus on the grief experienced by parents who had suffered the death of a child. These researchers employed a mixed-methods approach for their investigation: the quantitative results are explored in this 2008 article, and the qualitative results form the basis for Lichtenthal and colleagues (2010) article, discussed next. For their study, they used constructs of normative grief and complicated (prolonged) grief.

The research team recruited a convenience sample of bereaved parents (n=157) by means of grief support groups and websites. Participants contributed to the study solely by written communication. Their participation included completion of a demographic questionnaire (assessing variables culled from the literature), two widely accepted inventories measuring grief symptomology, and written questions gauging the presence and process of meaning-making in their grief experience. In these researchers' conceptualization, the broader construct of meaning-making encapsulates two narrower

concepts of *sense-making* and *benefit-finding*, and these narrower constructs shaped the questions and interpretation.

The researchers found that the cause of death, the age when the child died, and the time since loss accounted for significant differences in terms of normative grief symptoms, although cause of death was here found to be the only predictor of complicated grief. When meaning-making variables were added into both of the regression analyses, sense-making emerged as by far the strongest predictor of postloss adjustment, with a particularly significant correlation between low sense-making and high grief intensity. Likewise, a strong relationship was also seen between so-called successful sense-making and lower levels of grief intensity.

Lichtenthal and colleagues (2010) describe the qualitative dimension of the above study, extending the investigation beyond simply *whether* meaning-making was associated with higher or lower symptoms of grief, but *in what particular ways* this meaning making was understood and experienced by the participants.

The sense-making themes characterized participants' efforts to comprehend the death. Notably, nearly half of the sample responded by stating that no sense could be made of the death, or that sense-making was a futile effort. Among those who did identify one or more experiences of sense-making, the most prevalent themes revealed that many participants drew upon a spiritual or religious worldview to comprehend their loss. Another prominent sense-making theme had to do with comprehending the death as the event that released the child from suffering.

Likewise, with regard to the open-ended question about benefit-finding, the most prevalent finding—seen in 21% of the sample—was again that no benefit was experienced. Among the participants who endorsed finding some benefit in their experience, however, prevalent themes had to do with helping others, experiencing a newfound appreciation for life, and experiencing personal growth, enhanced spirituality, or deepened relationships. Multiple participants also spoke of reorganized priorities—intentionally seeking to live more meaningful or fulfilling lives in the wake of their loss, and experiencing this to be beneficial.

The researchers found that parents who directly expressed no sense-making and no benefit-finding in their loss scored higher on the grief symptom measures. Among participants who endorsed one or more examples of meaning-making, grief symptoms were seen to be less severe. Greater sense-making in terms of spiritual beliefs appeared to predict lower levels of maladaptive grief symptoms, as did the consolation that one's child was no longer experiencing suffering. In terms of the benefit-finding themes, analyses revealed that parents who described how their loss inspired them to change priorities—toward living more genuine and meaningful lives—experienced lower grief symptoms.

Perhaps the most unique contribution of the qualitative component of this study was in identifying ways in which participants who did endorse meaning-making understood and described this.

Experience of growth in bereavement adaptation. Next, attention is given to two further studies that extend an interest in meaning-making, but specifically within the

context of posttraumatic growth. Tedeschi and Calhoun (2004) offer a model as to how growth can emerge out of devastating loss. In their model, growth is generated when disorienting experiences compel one to shift and change key assumptions in order to adapt to a new reality. For some, bereavement can certainly be the disorienting event that forces an experience of recalibration and adaptation. However, not all persons experience growth in their bereavement. The two studies below each engage this growth model in their studies of grief responses to bereavement.

Davis, Wohl, and Verberg (2007) offer a unique perspective into patterns of adaptation after a significant loss. Their mixed-methods investigation is distinctive in that it examines one community of people who share in common the experience of having lost loved ones to a particular tragedy. Their study sample is comprised of family members left bereaved by a tragic mine explosion in Nova Scotia, Canada, that killed 26 miners. Davis and colleagues' engage Tedeschi and Calhoun's (2004) model of posttraumatic growth and explore to what degree the profiles seen in their sample correspond with this model.

This study was retrospective, conducted some eight years after the mining tragedy. The study sample was comprised of 52 individuals, all first-degree relatives of the 26 miners who were killed. Interestingly, the bereaved individuals agreed as a community to participate in the study. The investigation was shaped by a blended use of quantitative and qualitative measures. Participants first completed standard quantitative measures of emotional adjustment—namely, inventories assessing depression and psychological well-being. Further, they answered a series of closed-ended questions

designed to measure the construct of "loss salience," or the degree to which participants continued to mentally engage their experience of loss. Finally, participants answered a series of open-ended questions in a narrative interview, which invited personal reflection on their experience of loss and on any implications or meaning they derived from the experience.

The investigators utilized a phenomenological approach to analyze the transcribed interviews and to categorize the experience revealed in these narratives. Three distinguishable subgroups within the sample were identified, which the researchers titled (1) *Rebuilt Self*, (2) *No Meaning/No Growth*, and (3) *Minimal Threat/Minimal Growth*. The *Rebuilt Self* cluster was so termed because this group described a process of having deeply experienced a threat to sense of self—even a loss of self—in their bereavement, yet over time found ways to make meaning of their loss and ultimately experience a sense of personal growth. The authors note that this pattern most closely reflects Tedeschi and Calhoun's (2004) posttraumatic growth model. Participants within the *No Meaning/No Growth* cluster had found little sense of meaning, growth, or benefit from their experience, despite still actively trying to process their loss. Again referring to the posttraumatic growth model, the researchers suggested that this cluster would be hypothesized as unlikely to experience personal growth from their loss. The *Minimal Threat/Minimal Growth* cluster, in turn, did not appear to have experienced a notable upheaval in their bereavement, nor did they actively search for meaning in the loss experience. While this group did report personal growth, the authors speculate that this

growth was a *continuation* of development rather than a *transformative, changed* trajectory of growth.

Interestingly, the three groups showed no significant differences with regard to psychological adjustment. In other words, it did not appear within this sample that a meaning-making process or the experience of posttraumatic growth correlated with greater adjustment. Rather, all three clusters were found to fare equally well in terms of depression levels and general psychological well-being. The authors use these findings to suggest that adjustment can occur by diverse pathways.

A strength of this study is that it advocates for further clarification and nuance in understanding posttraumatic growth, including the role of meaning-making. While the authors appear to value Tedeschi and Calhoun's (2004) model, they urge for more exploration of diverse pathways to adjustment. They posit that it may be important to narrow and clarify the definition of posttraumatic growth to describe the experience of some, but not as an explanation of healthy grief for all.

In the final article to be considered in this section, Gamino, Sewell, Hogan, and Mason (2009) take up the topic of *Who needs grief counseling?* Their question was spurred in part by a debate generated by a controversial meta-analyses of the effectiveness of grief counseling (e.g., Larson & Hoyt, 2007), by Bonanno's (2002) findings of very distinct patterns of grief and resilience, and by their own stated commitment to the important role of grief therapy. Like the Gamino (2004) study described above, this study was part of a multiphase project.

Gamino and colleagues layer their inquiry of *Who needs grief counseling?* over a series of interrelated questions about bereavement adaptation. Their primary research questions explored the following: broad patterns of bereavement responses; distinctive features of very adaptive versus less adaptive responses; factors that complicate adjustment to loss; which participants sought out professional counseling; and what diverse grievers may seek from counseling.

The researchers employed both quantitative and qualitative measures in their study of 69 bereaved adults whose loved one had died between 12 and 40 months prior. Through use of cluster analysis, three groups were identified and classified as *High Grief* (*n*=16; showing high distress and low growth), *High Growth* (*n*=32, showing low distress and high growth), and *Low Impact* (*n*=21, characterized by low distress and low growth). Using variables derived from the social support inventories, the essays, and the interviews, the researchers then employed a series of pair-wise discriminant function analyses to further contrast the three clusters and understand their distinguishing characteristics. The *High Grief* group was the most clearly differentiated from the others, whereas the distinction between the *High Growth* and *Low Impact* groups was not as robust, but approached statistical significance.

The *High Grief* cluster exhibited particular difficulty coping with and assimilating to their loss, experienced significant emotional distress, and revealed little sense of growth from their loss. They were also the most likely to seek professional help (50% did so) and clearly desired relief from their distress. The *High Growth* cluster was characterized by lower degrees of bereavement distress and by an adaptive quality to how

they responded to their loss. This group seemed to engage their grief and actively sought to adapt and heal by various avenues, although only some 20% of this group reported accessing therapy. The *Low Impact* group, in contrast, appeared to experience grief in a more muted way. The death of their loved one did not seem to create as much of a sense of upheaval or notable distress, nor an opportunity for growth, as was seen in their counterparts. Interestingly, their help-seeking (20%) was disproportionately in the form of medication rather than grief counseling.

A particular strength of this study was its blend of quantitative and qualitative methodologies. Combining the strong psychometric measures with the narrative and voice of the participants permitted convergence of salient themes and offered a nuanced view of the ways participants responded to their grief. Participants grieving a death by suicide or homicide—though few in number (n=4)—were found to be in the *High Grief* group. The *High Growth* group, in turn, included a disproportionately high number of persons grieving those who died in tragic accidents or combat deaths.

The authors' commitments and perspective as clinicians were evident in this article. They sought to identify areas of greatest distress, to take note of who seeks out mental health care, and to consider how counseling might best serve those accessing care. Although initially asking the question of who *needs* grief counseling, Gamino and colleagues also end up asking a related question of who *wants* grief counseling. While it appeared clear that the highest level of need was exhibited in the *High Grief* group, still fully half of this group did not access counseling. The clinician's perspective also led Gamino and colleagues to ask the valuable question of what might be learned and

transferred from the experience of the *High Growth* cluster. The authors explained, "Observing how more adaptive individuals effectively navigate the aftermath of the loss of an important loved one may be the key to understanding how to aid and assist those who are struggling to survive and carry on following bereavement" (p. 202).

Synthesis. The articles reviewed in this section highlight multiple needs, experiences, and strengths among those who grieve and thus invite personalized response for counseling. While representing different frameworks, each of the above studies illuminate the importance of exploring the client's identity and narrative in experiences of significant loss and transition. These studies caution therapists to check their own assumptions as to what might be needed or wanted by grieving individuals, so as best to individually support those who are suffering loss.

A premise of the scientist-practitioner model is that research is driven by the real needs of practice, and practice in turn is informed by the research in the field. This interplay is evident in the studies reviewed here, which together enrich professional understanding of both the universality and individuality of grief, and guide a more compassionate and informed response to human experience of loss.

Therapist Development Literature

A second domain of literature that is particularly salient to the current study is that of therapist development. While there has been a respectable amount of research on therapist development, a substantial portion if it has had a limited focus on the early development of practitioners surrounding their training years (Ronnestad & Skovholt, 2013; Skovholt & Ronnestad, 1992). For example, an influential model of therapist

training is the widely researched Integrated Developmental Model (2010) put forward by Stoltenberg and colleagues, yet its purview is primarily restricted to graduate level training. Given the current study's interest in the *experienced* clinician, two therapist development models are selected for discussion due to the fact that these have taken a professional lifespan approach to understand therapist processes of change over time, from early training through late-career senior therapists. Further, an international qualitative meta-analysis on the topic of master therapists is considered, selected because it draws upon multiple studies of senior therapists recognized by their professional colleagues as experts in their field.

Lifespan models of therapist development. Attention is first given to Ronnestad and Skovholt's *Cyclical/Trajectories Model of Therapist Development and Stagnation*. The foundation for the model was a cross-sectional, longitudinal qualitative therapist study. The researchers examined whether and how therapists' professional development progressed as they gained greater experience. They initially interviewed 100 therapists, ranging at from graduate students to senior professionals. These results were first presented in a book titled *The Evolving Professional Self* to indicate how professional development is a multi-year and multi-decade process (Skovholt & Ronnestad, 1992). Ten years later, 60 of these professionals were interviewed in a second wave of the longitudinal study. The limited geographic scope and qualitative methodology necessarily limit the generalizability of this study. However, the generous sample size, cross-sectional and longitudinal design, and in-depth, in-person exploration of the topic yielded a wealth of rich data that are instructive for understanding therapist development. The

findings of this substantial research endeavor have been published in a couple iterations, reflecting a process of reanalysis, reformulation, and subsequent condensation of their work over time. The current discussion focuses on Ronnestad and Skovholt's 2013 publication.

Based on their research, Ronnestad and Skovholt (2013) posited five phases of therapist development—Novice Student, Advanced Student, Novice Professional, Experienced Professional, and Senior Professional—each phase characterized by unique developmental foci and areas of growth. Further, the researchers identified 10 higher-order themes of therapists' professional development, which emphasized the lifelong process of professional development in this field. They found that at its best, such development is propelled by an ongoing commitment to self-reflection and an intense commitment to learn across years of the profession. Further, they found that optimal development involved an integration of the personal self, over time, into "coherent professional self" (p. 145). Professional development was found to be propelled by interpersonal sources of influence—clients, supervision, personal therapy, personal life—more so than by "impersonal" sources of influence, such as coursework or literature, although these were still valuable (p. 153). Prominent themes also suggest a decrease in anxiety and a concurrent increase in comfort level and confidence in the clinical work over time and experience in the profession. Perhaps this shift can be understood in light of another theme, that of a "realignment from self as powerful to client as powerful" over time in the profession, as clinicians came to a healthy understanding of the reach and limits of their influence (p. 159).

From this study, Ronnestad and Skovholt conceptualized a model of therapist development. Based on one of the key themes of their qualitative data, there was a recognition that not all therapists develop optimally. As such, their model emphasizes three potential pathways through both professional development and stagnation in this field. The first trajectory is of *optimal development* or growth. Here the therapist responds to an experience of difficulty or challenge in the work by reflection and learning, which allows for continued engagement of the work. The other two potential pathways depict *developmental stagnation,* characterized by exhaustion and disengagement, respectively. The second trajectory again highlights and experience of difficulty or challenge, yet the therapist responds with exhaustion and has difficulty reengaging the work, which may lead either to exiting the role or finding an avenue for reflection that allows one to reengage. The third trajectory is one toward disengagement over time, characterized by a lack of active reflection and optimal growth.

Orlinsky and Ronnestad (2005) likewise put forward an empirically grounded model of psychotherapy development, the *Cyclical-Sequential Model of Psychotherapist Development*. This grew out of an ongoing quantitative international survey study, now nearly three decades running, conducted by the Society for Psychotherapy Research's Collaborative Research Network. A broad primary aim of the study was to explore the nature and extent of professional development experienced by psychotherapists as their careers unfolded over time, as well as to uncover formative experiences and practices that impacted therapist development.

Orlinsky and Ronnestad's (2005) model grew out of quantitative findings of this large-scale study. The study used as its main instrument a lengthy questionnaire developed by the aforementioned research network in order to investigate psychotherapist development. The study sample was comprised of nearly 5000 psychotherapists who responded to this survey. These participants were diverse in terms of experience level, professional disciplines, theoretical orientation, practice settings, and nationality (although a majority heralded from Germany, the United States, and Scandinavia). Broad inclusion parameters with regard to the psychotherapist construct are limitations to their study. That said, the sheer size and international reach of the sample from which Orlinsky and Ronnestad draw their conclusions, and the empirical methods by which they do so, make their findings and proposed model valuable in the professional literature and to the current study.

Based on the distribution of data, the researchers conceptualized six cohorts organized by shared characteristics and phases of professional development: Apprentices, Novices, Graduates, Established Therapists, Seasoned Therapists, and Senior Therapists. Furthermore, they formulated a model of therapist development that has a dynamic interplay between both a positive developmental cycle (identified as *Healing Involvement*) and a negative developmental cycle (*Stressful Involvement*). The former is characterized by professional growth and satisfaction, a sense of skillfulness and positive coping. By contrast, the latter is characterized by depletion and dissatisfaction, and a sense of low skillfulness. According to the model, the two cycles can to some degree be experienced concurrently—together they help explain a professional's experience in this

work. As the authors explain, “The actual course of a therapist’s development is determined by the balance between these two interrelated and partially interpenetrating cycles” (Orlinsky & Ronnestad, 2005, p. 167). It should be noted that the most prevalent professional experience noted in the large-scale study was that of the *Healing Involvement* cycle, whereas the *Stressful Involvement* cycle was less common.

The researchers identified therapist characteristics with predictive value for each cycle. The following characteristics were seen for *Healing Involvement*: a flexibility with theoretical approach, a supportive work setting, breadth and depth of treatment modalities, and a positive work morale. Professional challenges were evident in terms of the *Stressful Involvement* cycle, along with unconstructive coping patterns and feelings of anxiety or boredom in the clinical work. Predictors of this cycle appeared linked to situational factors more so than therapist characteristics (Orlinsky & Ronnestad, 2013).

From these findings, the researchers identified four patterns of practice: *Effective Practice* and *Challenging Practice* were both associated with higher levels of *Healing Involvement*, and more than 75 percent of participants aligned here. By contrast, *Disengaged Practice* and *Distressing Practice* were the patterns that captured higher levels of *Stressful Involvement*. Notable for the current study, if not surprisingly, the findings showed that *Effective Practice* was higher among experienced therapists. There was a corresponding decrease in *Disengaged* and *Distressing Practice* among participants at the higher experience level (Orlinsky & Ronnestad, 2013).

Master therapist meta-analysis. In another therapist study with an international reach, Jennings and colleagues recently conducted a qualitative meta-analysis of seven

studies of "master therapists." Collectively, this study represented some 72 clinicians, in seven countries, who had been identified by their professional peers as exemplar clinicians. Jennings and Skovholt (1999) conducted the first such "master therapist" study, and subsequent researchers have replicated this study in other countries. This meta-analysis considered seven of these studies together, in an investigation of common core themes.

Through the meta-analysis process, eight consistent themes were found across these studies. A handful of themes from the original seven studies were not included in the proposed framework because they were not represented across studies, perhaps instead representing interesting cultural variability. The researchers organized these common themes into meta-categories and domains, then posited a relationship between these as a potential explanation for therapist development. First, they postulated a *learning* domain that captured themes related to "[l]earning processes that help therapist develop personally and professionally" (p. 261). Further, a *therapy* domain was identified, comprised of themes related to "[t]herapists' approach to practice and personal attributes that enhance interventions," among these a theme capturing "cognitive complexity and intricate conceptualization" (p. 261). Finally, a *humility* meta-category was understood in the model to be a potential pathway between these two domains.

Based on their qualitative meta-analysis, Jennings and colleagues proposed a directional relationship between their thematic findings, which formed a synthesis model of these studies. Namely, they conceptualized a loop that represents an ongoing growth process: where cognitive and conceptualization complexity in the therapy domain yields

humility in the master therapist, which in turn drives further learning and development, which in turn returns to nourish the therapy process.

Jennings and colleagues' study offers valuable information about the experience and characteristics of highly reputed, highly experienced therapists. Perhaps the most prominent constraint of this rich, international meta-analytic analysis—and the original set of studies it draws upon—is that it is arguable whether the peer-nomination process employed assures expertise of the sample (Hill, 2016); some academics question the use of peer nominations to find experts (e.g., Tracey et al., 2014). How to empirically measure expertise of therapists is a challenge that persists in the research literature, and limits the assertions of Jennings and colleagues' inquiry that the participants could be considered masters of this profession.

Integrating and summarizing three therapist development studies. The three studies considered here, and their related models, are helpful for the current investigation of experienced psychologists' encounters with client grief. The first two models above—Ronnestad & Skovholt (2013), and Orlinksy & Ronnestad (2005)—are derived from studies of the normative development of therapists. While these two studies and their related models are distinct from each other in key ways, they each provide a framework for understanding the *experience over time* and *experienced therapist* dimensions of the current study. From the extensive data of their large-scale studies, they each offer understandings of experiences and situations that prompt therapist growth or stagnation, and they propose different pathways of how such development might unfold over time. Taken together, they suggest that experienced therapists—as a whole—demonstrate an

integration of their personal and professional selves, an increased comfort level in being with and responding to client suffering, and generally a heightened sense of satisfaction and self-efficacy in their work.

Jennings' and colleagues (2016) qualitative meta-analysis of "master therapist" studies and resulting synthesis model likewise paint a portrait of the experienced therapist. While their inquiry was focused on the characteristics of exemplar therapists, the peer-nomination recruitment method and absence of empirically validated criteria to effectively determine expertise limit the conclusive reach of the claim of unique expertise in their sample. That said, the core characteristics of these highly regarded therapists offers valuable information to the present study of experienced therapists. While none of the three above studies had a focus on encountering client grief, as is the purview of the current study, their studies illuminated features of the impact on therapists of working many years with client suffering.

Therapist Work with Grief

In this third and final section, consideration is given to research that relates closely to the current study's focus. Based on a review of the literature, it appeared that few studies, whether by quantitative or qualitative means, have directly investigated therapists' experience of encountering client grief. Therefore, while empirical studies are highlighted where possible, a broader selection of related areas of inquiry are included, chosen because they were informative for the current study's emphasis on the experience and perspective of the therapist in working with issues of grief and loss.

The literature reviewed begins with attention to therapist variables in bereavement grief therapy. First, a quantitative study of psychotherapist-client dyads engaged in grief therapy is examined. Here the researchers examine the relationship between clients' perceptions of grief therapy and their therapists' grief about the death of a loved one. Following is a first-person account of a therapist's experience of working with bereaved clients, included for its skillful and detailed use of case examples and for its salience to the current study's topic.

Next a selected group is considered from the closely related area of therapist's experience of client death and dying. The first article examined is a phenomenological qualitative study of psychologists' experience related to death and dying, followed by a related conceptual article and first-person account of psychologists' experience of the natural death of a client. These are included for their inclusion of case examples in their discussion of the clinical and ethical considerations of working with anticipatory grief in the face of terminal illness.

Finally, focus is directed to another qualitative study that investigates the relationship of therapists' own significant personal loss to their clinical work. This section concludes by considering a book contribution to the discussion, valuable for its focus on how helping professionals are impacted by their work with issues of bereavement, grief, death, and dying.

Therapist variables in bereavement grief therapy. A quantitative study by Hayes, Yeh, and Eisenberg (2007) investigated the relationship between clients' perceptions of the process of grief therapy and their therapists' personal grief about the

death of a loved one. The research was informed by an interest in the impact of therapist countertransference on their clinical work, here specific to work with bereaved clients. The researchers hypothesized that the more a therapist was emotionally caught up in their own significant loss, the less they would be experienced by clients as empathic and credible. Further, the more immediate the therapist's sense of grief, the researchers' anticipated, the less they would be able to foster depth in session and a strong working alliance.

Hayes and colleagues utilized a battery of empirically validated measures in their study of 69 client-therapist dyads, which participants independently completed and returned via mail. Therapist participants also completed an empirically validated grief inventory, which assessed the degree to which therapists had resolved their grief as measured by present emotional functioning. Two key factors of *actively missing* the deceased and *acceptance* of death were identified. In turn, client participants completed inventories that measured perceptions of therapist empathy, effectiveness, working alliance, and session depth—four variables thought to be key indicators of the process of therapy generally and bereavement therapy specifically.

As anticipated, the findings showed an inverse correlation: the more therapists *actively missed* their deceased loved one (in other words, the less the therapist had worked through the loss), the less clients perceived them to be empathic. Conversely, the greater the resolution reached by the therapists in their loss, the greater the empathy experienced by their clients. However, there was no significant relationship found between the therapists' degree of missing their loved one and clients' rating of the other

dependent measures: therapeutic alliance, session depth, or therapist credibility. Furthermore, no meaningful statistical relationship was found between the degree to which therapists had accepted their loved one's death and any of the dependent measures.

These findings supported the notion that clients may experience therapists to be less emotionally available and empathic when the therapist's emotional energy is actively engaged by their own grief. Yet conversely, Hays and colleagues offer, their study findings indicated that with resolution and thoughtful attention, the therapist's "resolved" grief experience could deepen understanding and empathy in a way that would be perceived and valued by their clients, congruent with Carl Jung's (1951) notion of the "wounded healer."

As the researchers acknowledged, the extent to which conclusions can be drawn from the data are limited by a few factors, among these a low response rate and unknown variables regarding what motivated or dissuaded participation. The researchers wondered, for example, whether strong therapeutic alliances were overrepresented in the sample. Still, the results are helpful in that they draw attention and care to the potential relationship between therapists' personal grief experiences and their capacity for empathy.

In light of the above empirical study, which examined the relationship between therapist grief and the impact on the therapeutic work with bereaved clients, attention is next given to Osband's (2016) first-person account of a psychotherapist who specializes in grief therapy. In a contribution to an edited volume entitled *When Professionals Weep* (Katz & Johnson, 2016), Osband writes of her experience as a therapist who works with

bereaved and terminally ill clients. Acknowledging that her own bereavement experience with the death of her child helped direct her to this field, she writes of learning to recognize where her personal experience informs the work—allows her to relate with empathy—and where it hinders the work. Through three case examples from her own work with clients, she describes the importance of respecting the differences in grief experience and types of loss, so as not to assume similarity of experience or reaction. She described how work with clients fostered her awareness, learned over time, about what touched on her own loss and grief. She acknowledged being challenged by engaging with bereaved clients, writing of the necessity of doing her own grief work through therapy, mind-body awareness, and attention to dreams. And she also described the sense of privilege of being entrusted with client's grief and supporting their healing.

There are limitations, of course, to first-person accounts, such as this and others that follow—as they are carefully crafted and are retrospective in nature. Yet, the first person genre allows in-depth, considered descriptions of clinical learning that was both challenging and vulnerable for the therapist, and is a valuable contribution to the literature.

Therapist work with client death, dying, and anticipatory grief. Foster & Vacha-Haase (2013) conducted a phenomenological research study focused on the experience of licensed psychologists encountering client death. With a slightly different angle of inquiry than the current study, the similarity in research design, phenomenological inquiry into therapists' experience, and a related focus on anticipatory grief and death and dying made it valuable for consideration.

The researchers, guided by clinical interests in gerontology, noted the dearth of research on therapists' experience of the natural death of a client, this despite the "graying of America" that makes this experience all the more salient for practitioners. To this end, they conducted a qualitative study of licensed psychologists who work with older adults. The aim of their research was a phenomenological investigation of how these practitioners were impacted by death of clients, and a related question of how practitioners cope with the increased likelihood of experiencing client death given their aging client population. Using a qualitative approach, Foster conducted semi-structured telephone interviews with ten licensed psychologists whose clients were predominantly over 65 years of age, and who had experienced the non-suicidal death of a client. While not a specific criteria, a majority of the sample practiced as geropsychologists in diverse settings.

Utilizing Interpretative Phenomenological Analysis methods for data analysis, several themes emerged. First, participants spoke of developing *a different mindset* when working with older adults, from which they had come to view death as natural and to be expected, not viewed as negative. Participants also acknowledged a personal shift over time toward a kinder acceptance and acknowledgment of one's own emotions in response to the death, whether feelings of sadness and grief, closure, or at times relief. A second theme related to *circumstances of memorable client deaths*—whether due to the particular therapeutic bond, a sense of professional satisfaction in their work, or specifics of the death event itself. The next theme captured clients' discussions of *personal and professional boundaries*. This theme included acknowledgement of how personal

experiences and issues with death impacted their clinical experience, and vice versa, how experience with client death influenced their personal experience. A fourth theme addressed the *impact of client death on clinical work*, both on a near-term and long-term basis. Near-term impact included the challenge of navigating emotions and focus after news of the death, while participants conveyed that the long-term impact was that they became better psychologists, with increased clinical ability. The final theme was that of *developing specific coping processes* within their professional life to thoughtfully navigate these endings and transitions.

Some limitations to the study must be acknowledged—such as limited demographic diversity within the sample, a sizeable range of licensed experience from somewhat newly licensed clinicians to senior therapists, and a range in experience from only handful of client deaths to a sizeable number amongst senior geropsychologists. One wonders how thematic findings may have been similar or different were there sufficient participants to examine differences across phases of professional development, or perhaps conducting separate studies of the experience of novice clinicians and senior clinicians. Findings from a qualitative, phenomenological study such as this are not meant to be generalizable. Rather their strength is the in-depth, nuanced reflections from clinicians that serve to prompt professional growth and awareness as well as further research directions.

Another salient article is authored by Dwyer, Deschields, and Nanna (2012)—three health psychologists—who draw on their work in hospital settings to describe their learning and professional perspective on the experience of losing a client or patient to

natural death, whether unexpected (such as an accident) or anticipated (such as through terminal illness). These authors note that while psychologists in all clinical settings can experience the natural death of a client, it remains a topic insufficiently addressed in the psychology literature. Utilizing two case examples, they discuss concrete issues pertaining to navigating and coping with professional loss. They write from the perspective that because therapy is interpersonal in nature—grounded and supported by empathic and emotional connection—one can expect that the professional would feel impacted by the loss of the client. Further, because work with clients experiencing terminal illness includes attention to anticipatory grief and existential concerns, attention to one's own experience is essential, in order to provide client-focused, competent, and ethical care.

Dwyer and colleagues highlight both professional and personal aspects to be considered when the natural death of a client brings the therapist into uncharted territory. *Professional* factors included commitment to protecting the client's continued right to privacy, for the sake of the client, their loved ones, and the integrity of the counseling profession. This can be challenged as there may be communication with the patient's family members following a death. Further, they discuss finding the balance of honoring the therapist's emotional response to the loss, while continuing competent and responsive care to their other patients. *Personal* factors included the therapist's own grief—whether due to a particularly positive emotional bond to the client, or complicated by more difficult feelings about the client—and the potential sense of unfinished business or lack of closure with the therapy work. Further, these authors acknowledge that the therapists'

own personal sensitivities to loss or grief may be activated by experiencing the death of a client, which the therapist must be aware of and attend to, particularly if elements of the loss touch on the therapist's own personal experiences or fears. Use of peer consultation is put forward by these authors as particularly valuable, both for the sake of ethically and competently navigating the professional decisions at this time—such as related to communication with family, or attendance of a funeral—as well as for emotional support around a grief experience that cannot be shared with others in the therapist's personal life.

A second conceptual study by is considered next, again for its salience to the topic and for its in-depth use of a personal case example. One key way that psychologists may work with client grief is in the area of terminal illness, when anticipatory grief is very present. This opens the door for therapist grief, as well, in a therapeutic relationship that will end with the client's death. O'Brien (2011) offers a first-person account that features an in-depth case example as a means of examining work with client death, dying, and grief. A psychologist active in clinical practice, who has fostered a specialty in grief among other areas of clinical focus, O'Brien chronicles his work with a particular client through terminal cancer. Particularly germane to the current study, O'Brien discusses how therapy included traversing the client's anticipatory grief and anxiety related to the terminal illness, and also addressing past grief and loss that emerged for the client.

Among the many strengths of this article, O'Brien's emphasis can perhaps best be distilled to a focus on the ethical considerations present when working with issues of death and dying and the countertransference challenges that can emerge for the therapist.

He highlighted lessons learned through this clinical work, including the importance of therapists' attention to their own grief experiences that might resurface. He emphasized the essential role of self-awareness and personal work on the therapists' own losses, utilizing consultation and therapy. Likewise, he described the importance of monitoring one's own death anxiety, having recognized his own resistance to talking about death, lest doing so somehow convey a loss of hope. O'Brien identified ethical considerations that informed intentional yet boundaried use of self and experience through disclosures to the client. He highlighted the importance of bearing in mind whether or not disclosures were clinically indicated. Yet, when fitting, he identified such self-disclosures to be essential to normalization of loss for the client, opening the door for meaning-making of loss.

Like Hayes and colleagues (2007), discussed above, O'Brien found value in the Jungian concept of "wounded healer." He normalized that practitioners have had personal experiences that are brought to bear in the therapist role, and he cautioned that mindful attention to this is essential so that such "wounds" do not impede the therapeutic alliance or hinder the effectiveness of treatment. Personal experiences that have been explored and processed—and continue to be monitored—can be the source of useful interventions with clients, he asserts, which may deepen the work.

Impact of therapists' own loss experience. In a related vein, examined next is research that highlights the impact of therapists' personal loss experience on their clinical work. Kouriatis and Brown (2013) conducted a phenomenological inquiry into therapists' experience of loss, with attention to how this related to their work with clients. While

there is considerable literature on therapist's experience of loss in terms of client terminal illness—as seen above—and client suicide, Kouriatis and Brown intentionally choose a more open construct, that of "significant personal loss." Motivated by awareness of "disenfranchised loss" (Doka, 1989)—which relates to grief for a loss that, for whatever reason, cannot be recognized openly or mourned publically, the researchers sought to make room in their inquiry for participants to identify what losses had been personally significant. By doing so, the interviews generated a much wider offering of what constituted loss in the participants' lives—from personal bereavement and professional bereavement (client death), to divorce, the sense of loss when a participant's child developed schizophrenia, or the loss of homeland through relocation.

Kouriatis and Brown's study sample was comprised of six experienced psychotherapists –defined here as having practiced five years or more—who participated in in-depth, semi-structured interviews. Interpretative Phenomenological Analysis was employed. Three broad, master themes emerged through inductive, recursive data analysis. The first of these—*the grieving therapist*—captured participants' descriptions of their own experience of grief and how it affected them psychologically, cognitively, physically, and relationally. Participants' coping with bereavement also fell within this theme, from receiving personal and professional support, to focusing energy into other clinical work, to engaging in their own meaning-making process. A second theme—*hindrances in grieving*—gave an account of the obstacles participants experienced, whether in terms of internal obstacles or from other sources, such as when the grief was not able to be sufficiently recognized or respected, such as due to professional

confidentiality. A final theme—*the impact of loss on therapeutic work*—referred to the many ways in which participants' loss challenged their work, as well as ways they felt their work was enhanced. Participants identified challenges related to feeling emotionally vulnerable in their grief, and spoke of a pull at times to over-identify or be overly directive with their grieving clients. At the same time, participants described advancements in their clinical work in terms of increased awareness and empathy.

A particular strength of this study was its commitment to letting participants identify the losses that have been personally significant. This study highlighted the nuanced ways in which therapists' experience of loss impacts clinical practice.

Also on the topic of the impact of therapists' personal loss experience on their professional work, one additional work is considered. Katz and Johnson's (2016) edited volume, "When Professionals Weep," examines the experience of helping professionals—psychotherapists, hospice social workers, chaplains—who work with palliative and end-of-life care. As the title conveys, the book examines the challenges of countertransference within this work, exploring its power to help or hinder the helping relationship. The editors—themselves a psychologist and psychotherapist—acknowledge that the understanding of countertransference within the field of psychology has evolved over time. Whereas the early analytic understanding of countertransference framed the experience unequivocally as an impediment to therapy, a contemporary and broad understanding of countertransference is that it is a potentially constructive therapeutic tool. These authors offer that countertransference is "part and parcel of all helping relationships," an invaluable gauge of what's happening, so long as the helping

professional is self-reflective and willing to tune in to the dynamic (p. 31). Countertransference "beckons helpers to look at their humanness in the face of serious illness, death, dying, and bereavement rather than avoiding it (p. 30). It has to potential to be "the basis for empathy, compassion, and a deeper understanding of both the patient's and the clinician's own processes" (p. 31).

This book is integral to the discussion at hand because it recognizes the self of the helping professional in the dynamic. Countertransference reactions are more diverse than "compassion fatigue" or "vicarious traumatization," the editors assert, and serve to highlight the "personal-professional interface" of this work (p. 33). The chapters included in this book highlight the value of active self-reflection about the personal impact of the work, as the clinician's responses and actions in turn impact the therapist to unwittingly overfunction or hold back. As editors offer, "We examine what we bring to the therapeutic relationship and, conversely, the ways it impacts us" (p. 34).

While this book is not an empirical study, it is included here because it speaks directly to the self of the helping professional in the helping dyad when working with issues of grief—specifically related to illness, dying, and bereavement.

Synthesis

The early sections of this chapter explored selected literature and research related to two primary domains: the grief literature and therapist development literature. Within the broad interdisciplinary grief domain, particular attention was given to empirical studies that highlight the contemporary discourse on grief within the discipline of psychology and closely related fields. Next, attention was given to a different and smaller

body of literature focused on the person of the therapist. Three key studies reviewed from therapist development literature were selected for their attention to therapist development across the professional lifespan, given the current study's focus on experienced therapists. This chapter's review concluded by examining a selection of studies and conceptual articles that integrate these two domains, focused on the therapist's experience of working with issues of grief.

This review indicates that within both the robust grief and loss literature and the substantial literature on therapist factors, surprisingly little empirical attention has been given directly to therapists' phenomenological experience of working with client grief. This current study addresses this gap, with its purpose to investigate the impact that working with issues of grief in this relationship-intensive profession might have on the person of the therapist, and to explore how seasoned therapists time and again open themselves to encounters with client grief. By extension, the study aimed to support therapist competence with issues of grief, so as to respond effectively and with care to client grief and suffering.

Chapter 3

Methodology

The overarching purpose of this study was to explore seasoned psychologists' experience of working with issues of grief, investigating what meaning and understanding they draw from having worked with grieving clients over time in the counseling profession. Specifically, this study investigated how experienced psychologists have been impacted by recurrent close proximity to client's experiences of grief and loss, how they time and again open themselves to and engage this dimension of their work, and how they maintain vitality while doing so. A qualitative, phenomenological approach was selected to allow for a complex understanding of the experience to emerge through themes derived from in-depth interviews on this topic.

This chapter presents the qualitative research approach taken in this study. Particular attention is given to the research paradigm and philosophical lens underpinning the study, and a rationale is offered for the data analysis methods utilized. The chapter then includes an overview of details pertaining to the study participants, including inclusion criteria, method of recruitment, and interview process. Next the chapter moves to a description of the data analysis process employed. Procedures used to implement the study and analyze the data are described, with attention to measures engaged to enhance the rigor of the study.

Methodological approach

This study employed a qualitative approach, guided by a constructivist-interpretivist paradigm and utilizing a phenomenological research design. This paradigm

and research design fit naturally with the study's aims to explore the lived experience of therapists encountering client grief.

The constructivist-interpretivist paradigm is characterized by a search for understanding particular human experience by means of exploring the perspectives of multiple individuals and attending to the meaning they attribute to that experience. As Morrow (2007) describes, a research *paradigm* is the set of beliefs that directs action; it is the "net" that holds the researcher's assumptions regarding research ontology ("one's view of the nature of reality"), epistemology ("how that reality is known"), and axiology ("the place of values in one's research"), which in turn informs methodology (p. 212). The constructivist-interpretivist paradigm is rooted in a relativist ontology, which recognizes a plurality of experience amongst the participants and the researcher. Further, it is shaped by a subjectivist epistemology, which sees a co-constructive process between researcher and participant. In terms of axiology, the constructivist-interpretivist paradigm assumes that a researcher's values are present in any research endeavor, and reflexive practices are used to illuminate and appropriately limit the reach of these. This constructivist-interpretivist paradigm is informed by a naturalistic influence on methodological procedures, which in the current study guided the choice to use in-depth interviews with participants in their place of practice (Denzin & Lincoln, 2017; Morrow, 2007). Within the constructivist-interpretivist paradigm, there is a recognition that the subjective meanings participants offer are contextualized historically and culturally; likewise, the researcher reflects on the potential influence of his or her own culture or context on the interpretive process (Creswell, 2014). Morrow (2007) asserts that research

designs within a constructivist-interpretivist paradigm are especially suitable to counseling psychology, congruent with the constructivist dynamic of psychotherapy.

A phenomenological research design was selected for its congruence with the research aims. Specifically, the study was guided by Interpretative Phenomenological Analysis (IPA) (Smith, Larkin, & Flowers, 2009), a research design within qualitative inquiry that is committed to investigating how people make sense of particular lived experience. Formulated by British researcher Jonathan Smith in the mid-1990s, IPA adheres to long-standing qualitative strategies and phenomenological commitments and is clearly situated with the constructivist-interpretivist paradigm. Three major theoretical axes shape IPA: It is at once a phenomenological inquiry, a hermeneutical—or interpretative—endeavor, and idiographic in nature (Smith, Flowers, & Larkin, 2009). These theoretical underpinnings may be further described as follows.

Phenomenological. First, IPA is anchored in the tradition of phenomenological inquiry. This has roots in a philosophical approach to the examination of experience initiated by the work of German philosopher Edmund Husserl early in the twentieth century. Husserl sought to examine how one might understand an individual's own experience of a phenomena and identify the essential qualities of that experience. Later philosophers—Heidegger and Merleau-Ponty, in particular—added complexity to this philosophical tradition by calling for a more contextualized rather than transcendental phenomenology, claiming that Husserl's "essential qualities" of an experience cannot fully be known apart from relationships, culture, and language (Smith, Flowers, & Larkin, 2009; Larkin & Thompson, 2012). As Smith and colleagues (2009) note, these

later philosophers facilitated understanding "that the complex understanding of 'experiences' invokes a lived process, an unfurling of perspectives and meanings, which are unique to the person's embodied and situated relationships to the world" (p. 21). The phenomenological tradition has therefore included diverse formulations and emphases over time, yet is held together by a shared interest in the experience of being human. IPA is a qualitative research approach that joins a psychological perspective to this phenomenological philosophical tradition through an interest in exploring how human beings make sense of lived experience (Smith, Flowers, & Larkin, 2009).

Hermeneutical. IPA is also grounded in the hermeneutical tradition, which refers to the theory of interpretation. An older philosophical tradition than phenomenology, it reaches centuries back to early scholars' wrestling with what constituted appropriate interpretation of the biblical canon. While the hermeneutic tradition emerged with regard to interpretive dimensions of ancient texts, it has been incorporated into newer currents of literary and psychological thought. There is necessarily an element of interpretation when one seeks to understand another person's experience—such as through a qualitative research endeavor—and the hermeneutic tradition prompts one to consider the reaches to which one can uncover and understand the original meaning of another person's words. Heidegger was a key figure in bridging the traditions of phenomenology and hermeneutics, and IPA can be placed within this Heideggerian phenomenological approach. As Smith and colleagues (2009) explain, "Following Heidegger, IPA is concerned with examining how a phenomenon appears, and the analyst is implicated in facilitating and making sense of this appearance" (p. 28).

Idiographic perspective. The third conceptual hallmark of IPA is its ideographic perspective, with the *particular* as the starting point and primary concern, anchoring any movement toward the *general*. This is consistent with the directional arc of qualitative study—taking one person's verbal description of lived experience and connecting it to others to web a general picture--and aligns with the phenomenological emphasis on the particularities of lived human experience. The idiographic framework is concerned with the depth and complexity that emerges when one attends to particular, individual experience of the "person-in-context" (Larkin & Thompson, 2012). It therefore makes knowledge claims about the individuals under study, with potential implications for a larger group level (Morrow, 2007), which is distinct from a nomothetic approach primarily concerned with making claims at a broader group level. As Smith and colleagues (2009) explain, IPA's idiographic perspective plays out in two particular ways: First, there is an interest in the particular in terms of detail and depth of research analysis, and second, there is a commitment to the particular in terms of close attention to how individual participants in their unique contexts have understood the phenomena in question.

As will be seen in the pages that follow, these three theoretical axes of IPA inform such matters as sample identification and recruitment, data analysis approach, pattern of theme derivation, researcher reflexivity, and strategies to ensure methodological rigor.

Participants

Consistent with the research approach and paradigm of the study, a purposeful and criterion-based sampling method was employed with the aim of recruiting

participants able to speak meaningfully to the topic and willing to contribute their time and experience (Creswell, 2014; Smith, Flowers, & Larkin, 2009). The research aims shaped the parameters of this purposeful sampling. The following inclusion parameters were selected to guide recruitment: Doctoral-level psychologists within an identified metropolitan area in the Upper Midwest, with greater than 10 years of clinical experience since earning their doctorate, for whom clinical work has been the primary professional role, and actively engaged in counseling / therapy practice (defined for this study as seeing 10 or more clients per week, on average).

Multiple factors informed these recruitment parameters. Given the study's inquiry into therapists' experience *over time* in working with grieving clients, participants were sought who had accumulated a certain breadth and depth of experience. In their work on therapist development, Ronnestad and Skovholt (2013) acknowledge that there is not a precise timeline for when one moves from the novice professional into the "experienced practitioner" phase, rather characterizing this developmental shift by a subjective combination of both duration and variety of experience (p. 98). Informed by other studies that utilize a phase model (e.g., Orlinsky & Ronnestad, 2013), experience of more than 10 years of post-graduate clinical work at the doctoral level was selected for inclusion. Certainly, there are a range of mental health professionals from various training paths (e.g., social work, marriage and family therapy) who could offer valuable insights to this topic area. A unified parameter of training and licensure was selected as a way to increase homogeneity in the sample within a mental health field represented by a range of

formalized training. Use of other samples in the "relationship intense professions" (Skovholt & Trotter-Mathison, 2016) would offer natural extensions of the present study.

Recruitment procedures. A systematic approach informed the recruitment procedures, with the aim of drawing a sample of 10-15 participants who could contribute meaningful, in-depth information to the study. There are wide-ranging recommendations regarding appropriate sample size in qualitative research, with some variation according to research design. Decisions regarding sample size in qualitative research often are guided by the concept of saturation, or data redundancy, referring to the point at which primary themes appear consistent and no substantive new themes are emerging from additional data. Based on their study assessing patterns of saturation, Guest and colleagues (2006) found a sample size of 12 to be sufficient for saturation of the data, a number echoed by others (e.g., Morrow [2007, p. 255] refers to the "magic number twelve," which she acknowledges is somewhat arbitrary).

Phenomenology's idiographic perspective, in which particularity and depth of human experience is prioritized over general claims, has not generally emphasized the concept of saturation (Gentles et al., 2015). Phenomenological research generally includes smaller sample sizes, such as when time-intensive or repeated interviews are used, and Smith and colleagues (2009) suggest a range of four to ten interviews. As much or perhaps more important than numbers of participants in a data-rich qualitative interview study are the quality, length, and depth of the interview data, asserts Morrow (2005). Finding a middle ground within these diverse recommendations, the researcher set out to interview 10-15 participants, with interview duration up to an hour. The

requested time-frame sought to balance the aim of in-depth interviews while respecting the value and limits of time for working professionals, whose day often is organized into clinical hours. The following recruitment procedures yielded a final sample of 12 participants.

The researcher's aim was to interview experienced counseling psychologists who were actively engaged in clinical work. To this end, the researcher procured a mailing list of psychologists actively licensed in the state, which was available to the public through the office of the licensing board. She narrowed this list according doctoral-level licensure and region, which yielded approximately 700 psychologists. As a necessary means to narrow this scope, she utilized university-based public online records to identify a list of Ph.D. graduates from a counseling psychology program within the same metropolitan area. Through a process of comparison and merging of these two lists, she identified approximately 80 individuals who met study criteria in terms of academic degree, active licensure, and years of post-graduate experience. Utilizing indicators from the mailing list and other online materials (therapist search engines and professional websites), the researcher narrowed this further to 54 individuals who appeared most likely to meet the eligibility criterion regarding professional focus as active clinicians (e.g., excluding those holding primarily administrative or academic positions). Given the target sample size of 10-15, the decision was made to first reach out to half of these. Recruitment letters were sent to 27 individuals.

Upon receiving approval from the University of Minnesota's Institutional Review Board, the researcher reached out to these 27 individuals, describing the study and

inviting participation. A personalized letter was sent via postal mail, followed shortly thereafter by an email inviting response as to willingness to participate (see Appendices B and C). From this recruitment effort, 15 individuals responded affirmatively within two weeks, volunteering to participate, which met the upper end of the identified sample size goal. Three additional individuals responded that they had retired and were no longer practicing. Of the 15 eligible respondents who initially responded, three did not follow up to the researcher's further communication regarding interview scheduling (see Appendix D), yielding a final study sample of 12 participants.

Participant sample characteristics. Brief demographic information is provided here in aggregate form for the twelve participants in this study, so as to honor the commitment to confidentiality regarding identification of individuals. In terms of gender, five participants identified as men and seven as women. Of the twelve participants, ten identified as Caucasian, and two identified as multiracial. Participants ranged in age from their forties to their seventies: three were between 41-50 years of age, one was between 51 and 60, five were between 61 and 70, and three were 71 years of age or older. Total years of post-doctorate clinical experience ranged from 11 to 29 years, with an average of over 19 years. The average length of time participants had been licensed as psychologists was nearly 22 years. Given changes in licensing requirements over the years, several participants had initially acquired licensure and were practicing psychologists at the master's level prior to completing the Ph.D., prior to then acquiring doctoral-level licensure.

The participants served as practitioners in a variety of settings. At the time of the interviews, seven worked in private practice, one in a community clinic setting, two in mental health agencies, and two in university counseling centers. Given the nearly 22-year average of post-licensed professional experience, it emerged through the interview process that the participant sample drew upon a broader array of counseling / therapy contexts through previous work history, including community and inpatient settings. In addition to their primary professional roles as practitioners, seven participants were involved at the time of interviews in supervision and training, consultative roles, teaching, or clinically related administration. Nine were engaged in full-time work at the time of the interview, while three worked on a part-time basis as these individuals cut back on hours while approaching retirement. In terms of the average number of hours directly working with clients per week, five participants reported 11-20 hours, two reported 21-30 hours, four reported 31-40 hours, and one reported 40 or more hours per week. However, it is important to note that every one of the research participants had thousands of work as practitioners with clients as part of their professional careers.

Materials

Demographic form. Participants responded to a brief demographic questionnaire (Appendix E) that assessed age, gender, race/ethnicity, date of highest degree completed, and years of licensed clinical practice. The demographic questionnaire also inquired about the counseling context in which participants worked, the range of professional roles inhabited, and the number of hours devoted to the provision of therapy.

Semi-structured interview. The researcher developed a semi-structured interview protocol for this study, comprised of a series of 11 open-ended questions (see Appendix F). The questions were guided by the research aims, informed by the existing literature, and clarified through a process of consultation with her advisor. The process of formulating the semi-structured interview protocol was informed by recommendations from the literature (e.g., Charmaz, 2014; Corbin & Strauss, 2015), such as a movement from broad introductory questions to somewhat narrower questions. One of the final questions in the protocol invited the participant to reflect on and describe a defining moment—a moment with lasting significance or meaning—related to their work with client grief (Trotter-Mathison et al., 2010). This question was aimed at inviting further specificity and personal narrative into the interview.

The researcher piloted the brief demographic questionnaire and the interview protocol through consultative interviews with two clinicians in the field who had similar experience as those that comprised the final sample. Both clinicians noted particular interest and experience in working with client grief. The purpose of these interviews was to assess the appropriateness and scope of the interview questions, including gauging the length of time appropriate for the interview protocol. Further, these pilot interviews provided an opportunity for the investigator to practice the interview process and receive feedback from these consultants about the nature and clarity of the interview questions. After these pilot interviews, the protocol was clarified and minimally adjusted. As these pilot interviews were for consultative purposes, they were not included in the data analysis process.

Procedures

Interview Process. The researcher conducted individual interviews with each participant at his or her office over a seven-week period from early March to mid-April 2017. Conducting the interviews within the participants' office setting provided another avenue for the researcher to seek to understand the participant's experience (Creswell, 2014). Participants were sent the interview protocol in advance of the interview so that they could be acquainted with the questions; likewise, they were sent the informed consent statement (Appendix A) and demographic questionnaire for their review. At the outset of the conversation, the consent statement was reviewed and discussed and the participant completed a brief written demographic questionnaire, after which the actual interview began. The interviews themselves lasted between 39 and 57 minutes (M=49), with time constraints in clinical schedules appearing to partly inform the duration of the shortest interviews. Another factor was that some research participants provide more concise answers while others were more expansive in their responses.

Within the constructivist-interpretivist paradigm, semi-structured interviews allow for a certain degree of flexibility with the interview protocol when needed to facilitate greater clarity or depth (Smith, Flowers, & Larkin, 2009). Therefore, while the same primary questions were asked of all participants, interviews diverged in minor ways. For example, when the flow of conversation naturally led to a question later in the protocol, the question sequence was rearranged to facilitate communication. Likewise, if the participant expressed confusion about the question, the researcher rephrased it and offered minimal prompts, when appropriate. At times, the researcher invited the

participant to draw out their response further (e.g., “Can you say a little more about that?”), or asked for clarification or an example, to deepen understanding.

The interviews were audio-recorded, after which the researcher transcribed each interview verbatim. All identifying information was removed in order to ensure confidentiality, and each transcript was assigned a participant number. After each interview was completed, and again as she transcribed the interview, the researcher recorded notes about her impressions about the content of the participants’ responses in order to better understand the context of the interview.

Data analysis

Research team. Along with the primary researcher, two advanced master’s students in counseling psychology, who would be continuing in doctoral programs in the same discipline, served as peer researchers by assisting in data analysis. A Ph.D. licensed psychologist served as independent auditor. The primary researcher was familiar with qualitative research, specifically Consensual Qualitative Research (CQR) (Hill, Thompson, & Nutt Williams, 1997), from prior research experience during her doctoral studies. The two peer researchers had taken master’s level coursework in research methods, although this was the first time they engaged in qualitative analysis. The independent auditor had participated in several previous qualitative studies and was experienced in the role of auditor. As independent auditor for this study, she reviewed the process, checked the data analysis procedures and outcomes, and ascertained that the data analysis was a systemic and transparent process, faithful to the voice of the participants. Throughout the research process, the primary researcher consulted about procedures with

her doctoral advisor, who has received three joint research awards for qualitative research, two in the United States and one in Norway, published four books on counselor / therapist development based on qualitative research, and served as the Ph.D. advisor for thirteen previous qualitative dissertations.

Researcher reflexivity. A widely accepted standard within qualitative research is that of reflexivity, a practice that calls for researchers to manage their own subjectivities and to inform their readers about their perspectives (Morrow, 2005). This process in anchored in the understanding that background, culture, experience, and assumptions may shape the lens through which the study unfolds and the data is analyzed, and furthermore might influence how themes are recognized and what meaning is ascribed to the data (Creswell, 2014). Reflexivity within the constructivist-interpretivist paradigm is aimed to ensure that the outcome is not skewed or dominated by researcher subjectivity, but rather is true to the participants' voiced perspectives.

The research team—composed of the primary researcher and two peer researchers—examined aspects of their own personal and professional identity that they brought to this study, exploring what might impact their relationship to the interview data. The team engaged both individually and collectively in this reflexive work.

The primary investigator acknowledged ways in which professional and personal experience informed interest in this research topic. For example, early work experience with refugees and asylum seekers deepened her personal interest in the issues of loss and grief that may accompany relocation and cultural adjustment. Previous clinical training as a hospital chaplain brought her into encounters with death, dying, and bereavement, and

experiences as a counseling trainee and doctoral psychology intern with grieving clients prompted a desire to deepen this dimension of her work. She found narrative perspectives from extensive previous undergraduate studies in literature and graduate studies in theology to be congruent with her interest in the qualitative and phenomenological approach and the encounters with human narrative and meaning-making they afford. She acknowledged that her approach to counseling and therapy was shaped by an integrative interpersonal theoretical lens, within a developmental, multicultural framework.

The peer researchers also considered how their professional and personal experience shaped their relationship to the research topic. One of the peer researchers described her past experiences with grief as primarily being personal, rather than professional, as her main clinical experience was working with culturally diverse students in an academic setting. She had also engaged in interpersonal violence work, both in a community shelter and a college setting, which she recognized to include themes around grief. She saw the research emphasis on grief to be an area of professional growth and was eager to learn from the study. The other peer researcher reflected on her previous professional experience as an academic advisor where she worked primarily with underrepresented, culturally diverse college students. Also a beginning practitioner, she expressed particular interest in the study's emphasis on experienced practitioners and their varied clinical experiences, viewing this as an opportunity for learning and challenge. Both peer researchers sought out further clinical experience and learning through upcoming doctoral studies.

As a group of three, the data analysis team considered identity variables within the group—such as age, race and ethnicity, cultural influences, evolving religious/spiritual worldviews, and professional experience—with discussion as to how these might influence the interpretative lens individually and as a group. Similarities were acknowledged within the group, as all members of the research team identified as female, had been raised in Protestant/Catholic families, currently attended a shared counseling psychology graduate program, and claimed a multicultural counseling framework informed by personal and professional experiences. There was modest diversity of age, race/ethnicity, marital status, current religious/spiritual perspectives, and clinical interests among the group. Within this conversation, each commented on their own experiences of grief and loss, including reflecting on how grief was expressed or ritualized within their families of origin, particularly with regard to bereavement. The research team acknowledged that none had yet experienced the death of an immediate family member.

In line with the reflexive practice of identifying potential assumptions or bias, the research team discussed and acknowledged broad expectations of the data, anticipating the following:

- Participants would draw upon experiences of significant personal loss to inform their work with grieving clients.
- Participants would report finding encounters with client grief to be meaningful—and at times charged—because of a sense of shared human experience of grief.
- Personal identity variables would be salient to practitioners' experience of

working with grieving clients. (For example: It was anticipated that cultural or religious/spiritual perspectives would be salient to the participants' experience of working with grieving clients.)

- Participants would offer learned wisdom on this topic, informed by extensive clinical work and a range of client experience over time as a clinician.
- Participants' approach to working with grief would be informed by their counseling theoretical orientation, grief research, and theory in psychology and related disciplines.

The researcher reflexivity process was ongoing, with intentional space throughout the data analysis process given to reflect individually and as a research team about reactions to the data. Especially when they prompted surprise or particular interest, the team examined what these reactions illuminated about subtle expectations. As just one example, an area of surprise voiced by one research team member early in the data analysis process related to a participant's difficulty answering the question about how personal identity intersected and informed work with grieving clients. The reaction illuminated the common parlance around identity currently prevalent in educational settings that was familiar to the research team, yet which wasn't necessarily commonplace for all participants. This discussion illuminated the need for greater clarity on the two interview questions related to identity, and it was agreed that prompts would be consistently offered with these two questions when additional interviews were conducted. This invitation to monitor reactions to the data allowed, in this instance, the

team to explore the personal importance of the question to team members and to notice the expectations brought to the data analysis process.

Methods training. Training was provided by the primary investigator, who gave materials and summaries to the research team regarding key facets of the methodology, and facilitated ongoing discussion about the qualitative procedures.

Data analysis procedures. Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009) guided the data analysis procedures. IPA directs the researcher's analytic focus toward the participant's efforts to make meaning of their experiences of encountering client grief. As Smith and colleagues (2009) note, there is a "double hermeneutic" at work, as the researcher seeks to make sense of the participant's efforts to make sense of their experience (p. 3). To this end, an inductive, iterative data analysis process was employed, with the goal of generating themes from the data. Within this framework, the directional arc is from the particular to the shared, and from description to greater interpretation and higher levels of abstraction, yet with the goal that final thematic outcomes capture and are consistent with the original data. A description of the data analysis process follows.

All three members of the research team (primary researcher and two peer researchers) analyzed the first two interviews, followed by mutual conversation and feedback. Adjustments to and clarification of the data analysis process were made at this time. Subsequent interviews were divided, so the primary researcher and one team member analyzed the remaining even-numbered interviews, and the primary researcher and the team member analyzed the remaining odd-numbered interviews. This method

allowed for the primary researcher to have consistent and deep engagement with all 12 interviews, while permitting additional data analysis perspectives across interviews. As Smith and colleagues (2009) note, the use of peer researchers can help test and develop the coherence and plausibility of the interpretations drawn from the interviews. When utilized within the constructivist-interpretivist paradigm, a team approach is used to ensure depth and complexity of understanding. Both the coding process and conversations about the data were therefore used to support a shared sense of understanding of the emergent themes. The research team was asked to take note of any reactions or questions they had as they read the interviews, and this process of questioning and conversation was used to deepen understanding and inform interpretation of the themes.

The process of coding and thematic development proceeded as follows: The researchers read the transcript in its entirety twice prior to beginning analysis. The first reading was simply to get a sense of the whole; the second, to notice any initial questions or reactions that emerged, and note these in exploratory comments. Then, a third close reading was aided by a coding process, in which brief codes—or summary statements—were recorded in the margin of the transcript, aiming to distill meaning units from the interview data into short phrases. Informed by this coded material, exploratory comments, and interview data as a whole, each researcher then generated a list of emergent themes, which were written alongside the other margin as they corresponded to the content of the interview. The primary researcher consolidated the emergent theme lists for each interview, yielding 15 and 25 emergent themes per interview. While several

of these themes ultimately overlapped at a later stage of analysis, care was taken at this stage to attend to the themes of each interview individually, consistent with IPA's ideographic focus (Smith, Flowers, & Larkin, 2009).

Only after emergent theme lists for all twelve interviews were identified did a process of comparing themes across interviews occur, searching for connections. This stage of analysis was primarily conducted by the primary researcher. A shared theme list grew out of these fourteen emergent themes, ultimately distilled to four superordinate themes. Growing out a similar inductive, iterative process to that described above, a thematic structure emerged from the superordinate themes. The primary researcher presented this structure to the peer researchers and auditor, where it was reviewed and discussed to ensure it reflected the team's interpretation of the interviews. Cross-case analysis was used to clarify and deepen understanding of the nature of these superordinate themes. Quotations from the interviews are used liberally in the results chapter to exemplify each theme. The use of quotations both allowed participant voices to be heard and anchored the superordinate themes in the original data.

Standards of Research Trustworthiness

Research rigor in qualitative research is marked by processes to ensure trustworthiness, or credibility. These processes are quality markers used to enhance confidence in the study's findings, and have emerged within qualitative research in as a methodologically appropriate response to concepts of reliability and validity within quantitative methodology (Morrow, 2005). Morrow (2007) puts forward four criteria that transcend research paradigms within qualitative research: adequacy of the data, quality of

analysis, researcher reflexivity, and rich descriptions of the participants' meanings, grounded in quotes from interviews. Transparency regarding these trustworthiness practices allows the readers to assess the relevance or transferability of the study findings to other contexts (Morrow, 2007).

These criteria, as elucidated elsewhere in this chapter, informed the trustworthiness practices employed in this study. Efforts were made to balance various factors that ensure *adequacy of the data*. These included sufficient numbers of participants, efforts to identify thoughtful inclusion criteria for the study sample, and efforts to ensure quality and depth of the interview (Morrow, 2007). Intentional strategies were employed to allow *adequacy of interpretation:* The primary researcher's immersion in the data (conducting the interviews in person, personally transcribing the interviews, repeated reading of the data, analyzing all 12 interviews) allowed for continuity and in-depth understanding of the phenomena. Furthermore, use of an independent audit helped ensure that the final thematic structure and interpretive claims grew out of a systematic analysis procedure; honored the perspectives of the participants; and didn't privilege interpretations that represented only a handful of the participants or were skewed by the biases of the researcher (Morrow, 2005). In terms of *researcher reflexivity,* strategies were employed to support self-awareness of potential biases or research assumptions that might cloud or inappropriately drive the interpretive process. These strategies included transparency regarding the researcher's assumptions and biases; the primary researcher's practice of recording notes about her impressions from the interviews in order to better understand the context of the interview; use of a research team, "who serve as a mirror,

reflecting the investigator's responses to the research process" (Morrow 2005, p. 254); efforts to engage and honor the perspectives of the research team; and the ongoing process of noting reactions to and asking questions of the data. Finally, to Morrow's fourth trustworthiness criteria, *rich descriptions of the participants' meanings*: The presentation of results, in the next chapter, utilizes numerous selected participant quotations, selected to demonstrate that the interpretive claims are anchored in the lived experiences of the participants.

Summary

Based on phenomenological inquiry within a constructivist-interpretivist paradigm, this qualitative study used Interpretative Phenomenological Analysis procedures (Smith, Flowers, & Larkin, 2009) to analyze semi-structured, in-depth interviews with experienced psychologists. Three researchers analyzed the data through inductive, iterative procedures, generating a thematic structure that captured participants' lived experiences when encountering client grief. Processes to maximize trustworthiness and credibility in the findings were employed.

Chapter 4

Results

This chapter presents the superordinate themes, themes, and subthemes generated in the qualitative analysis. A total of four broad superordinate themes—or master themes—were identified. A "superordinate theme" captures a pervasive topic that emerges from the data across all interviews in the study, though there is variability in expression of this theme among individual participants (Smith, Flowers, & Larkin, 2009, p. 166). The superordinate themes aim to capture convergence, while the themes under their umbrella reflect divergence or complexity within the superordinate theme.

Four superordinate themes were identified, comprised of seventeen themes that emerged from the data, most of which were further divided into subthemes for clarity and richness. With regard to communicating the frequency with which themes were addressed by participants, the following terms were employed for this study, informed by Smith and colleagues (2009): *all* [all 12 participants], *most* [8-11 participants], *half* or *approximately half* [5-7 participants], and *some* [3-4 participants].

The results are organized below in superordinate themes, themes, and subthemes. These arose from the data through inductive analysis. The themes that emerged reflected the broader phenomenological question that guided the study, regarding psychologists' experience of encountering client grief. Within this, the findings corresponded with yet reached beyond the identified research questions.

Numerous participant quotations are included verbatim throughout this chapter, to provide illustrative examples of the identified themes. Note that minor editing changes

were made to some of the quotations in order to increase clarity or to remove potentially identifying details.

Table 1 summarizes the superordinate themes, themes, and subthemes to provide an introductory, comprehensive view of the results, after which these will be described in narrative form.

Table 1.

Superordinate Theme 1	**Superordinate Theme 2**	**Superordinate Theme 3**	**Superordinate Theme 4**
An expansive understanding of grief	Drawing on personal and professional experiences with grief	The power of clinical experience in the evolving effective therapist's role	Factors promoting resilience when working with grief
Theme 1A: Grief as an expansive construct • **Subtheme:** Personal lived experience expands understanding of grief • **Subtheme:** Clinical experience expands understanding of grief **Theme 1B:** Centrality of grief to therapy • **Subtheme:** Transition and grief through a developmental lens **Theme 1C:** One size does not fit all with grief • **Subtheme:** No right timeline for grief **Theme 1D:** Recognizing context and complexity in grief • **Subtheme:** Intersections with other therapeutic concerns • **Subtheme:** Intersections with trauma **Theme 1E:** A hopeful lens: Beliefs about grieving well • **Subtheme:** Reframing grief • **Subtheme:** Witnessing client healing resilience • **Subtheme:** Client grief work can bring possibility and opportunity	**Theme 2A**: Drawing on own grief experience to inform the work • **Subtheme:** Experiencing own significant grief can make the work more complex • **Subtheme**: Informs empathy and understanding • **Subtheme**: Informs therapy interventions **Theme 2B:** Feeling the impact of client grief • **Subtheme**: When particularities of client grief touch one's own • **Subtheme**: When long-term clients experience grief **Theme 2C:** Purposeful use of self-disclosure **Theme 2D:** Therapist's own tears in session **Theme 2E**: Client death & dying • **Subtheme**: Working with terminally ill clients • **Subtheme**: Grieving sudden client death	**Theme 3A:** A shift over time from *'fixing'* to *presence* • **Subtheme:** Cultivating characteristics that support skillful work with grief **Theme 3B:** Using self and the therapeutic relationship **Theme 3C:** Being actively present with intense grief emotions • **Subtheme:** Utilizing own emotions and energy • **Subtheme:** Beyond sadness: Making room for complex grief emotions **Theme 3D:** Grief-focused interventions: Drawing upon theory • **Subtheme:** Flexibility with theoretical orientation when working with grief	**Theme 4A:** Energized by the integration of the personal and professional selves • **Subtheme:** Personal characteristics that fit well with this work • **Subtheme:** Life experiences primed for this work • **Subtheme:** Valuing the circular process between self and the work **Theme 4B:** Practices in personal life supporting resilience • **Subtheme:** Self-growth practices • **Subtheme:** Reflective & spiritual practices • **Subtheme:** Cultivating a full personal life **Theme 4C:** Practices in professional life supporting resilience • **Subtheme:** Consultation: Not going it alone • **Subtheme:** Continued learning: Nurturing curiosity and interest • **Subtheme:** Recognizing the reach and limits of one's role

Superordinate Theme 1: An Expansive Understanding of Grief

The first overarching theme to emerge from the interview data related to how participants understood grief and grieving. Under the umbrella of this superordinate theme, five narrower themes emerged: Grief as an expansive construct; Centrality of grief to therapy; One size does not fit all with grief; Recognizing context and complexity in grief; and A hopeful lens: Beliefs about grieving well. These themes naturally overlap to some degree, even as there are key distinctions between them.

Theme 1A: Defining grief as an expansive construct. Participants spent time voicing and clarifying their understanding of grief in terms of what this construct means to them and how they see client grief in their work. While to some degree *all* participants spoke of grief in terms of bereavement (defined as grief about death)—and offered primary examples of bereavement grief—*most* also spoke to the importance of a broader understanding of grief. Several expressed the value for them of understanding grief in an expanded way, while also conveying that their expanded understanding of grief grew over months and years of their time as a therapist and their own lives time. As will be seen in the quotations that follow, descriptions of grief ranged from bereavement specifically, to relationship loss more broadly, to what could be considered ambiguous loss (Boss, 1999) or disenfranchised grief (Doka, 1989). Participants' understandings of grief—and the reaches of what it means—were described through both personal and professional experiences with grief.

Subtheme: Personal lived experience expands understanding of grief. From their own lives, participants referenced grief in the following ways: bereavement (death

of family members—parent, child, grandparent; death in typical course of life and also sudden death or early death), divorce, coming out, loss or shift in valued role related to parenting or grandparenting, loss of pet, loss of job, being adopted, loss of home, relocation, shifts in belief framework, aging, and other shifts in identity.

Some participants referenced how a personal understanding of grief began in childhood, whether due to the death of a family member or due to a more ambiguous grief of unwanted relocation and change. One participant described the ways in which an understanding of grief grew from infancy:

> "I'm adopted. And so my life started with loss….I mean, I struggled as a kid with being in a family where I didn't look like anybody else and my interests were not the same. I had…[siblings] who are biological children of my parents."

Most participants spoke to how new understandings of grief continue to emerge as new stages of life and roles unfold. As one participant offered:

> "Grandmothering is an interesting experience. I wouldn't call it grief in terms of somebody dying, or that kind of thing--but your place with this child, your authority with this child, or your appropriate place with this child, is very different than as a parent. And so I've had some grief… I have a…[child] who got divorced--which is okay, I mean, I can live with that--but it's…made it really hard for us to see these kids. And while we have persevered, that's been a big grief thing, because I haven't been able to do nearly what I would like to do."

In a similar vein, another participant reflected on new insight into the layers of grief that can emerge as children grow and leave home, a transition that demands an identity shift in the parent. He translated understanding this dimension of grief into work with clients:

> "As you get older, things do change and there is loss. One of these things in my life was my kids growing up—I mean, this is normal, healthy stuff: kids growing up and moving out….Having had that experience, now I'm able to talk with clients who either may be in that same stage or people who had dealt with that…major transition, from being an active parent to a parent with your kids who

> have left. It's as significant as when you started school--and then you graduated from high school and went off to college and you had to create your own new identity. For an adult, when their kids leave, they have to create sort of a new identity."

One participant reflected on how another shift in identity—in the sense of coming out as LGBT-identified—had layers of loss, an experience which later allowed this participant to recognize similar grief in a client's situation.

> "I had a client, years ago, who I think because of his LGBT identity had to leave a fraternity, and was grieving the loss of relationships with fraternity members… I think [that grief] was really about losing people who couldn't accept that aspect of his identity. And it was something that really touched home for me, because of some of my own past experiences."

Subtheme: Clinical experience expands understanding of grief. From their clients' lives, participants referenced grief in the following ways: bereavement, loss of health or physical ability, dementia, terminal illness, miscarriage, death of child, aging, loss of a hope or dream, loss of pet, coming out, suicide-related grief, chemical-abuse related grief, loss of a career, and grieving the loss of a childhood.

One participant expressed the importance of taking a wide-angle view of grief in order to recognize the significance of clients' experiences of loss. As an example, she described how a client whose early life was marked by sexual abuse may experience significant grief about the loss of a childhood. "There have been really profound things," she continued, "about people resolving the death of their childhood that they know that they'll never get back, or never can."

Another participant, who had begun her career with a clearer focus on bereavement, described how the grief issues in her clients had shifted over time as both she and her clients have aged.

> "I thought it would just be a piece of cake, to be at this stage of my career, and sit with people my age and talk about how great life is. And instead I've got a couple of clients dealing with cancer, a…[client who] just lost an adult son, one of my clients found out Monday that he has terminal cancer as well….[Clients who are] young widows and widowers..."

Also reflecting on aging, another participant commented on the way he witnessed layers of grief present in his work with older adults.

> "I have a…[client who] used to be an incredibly vital, active woman. This is a woman who can't travel any more, has to nap all the time, is unable to be involved with her family in the way she was. And so there's this sequence of losses, and hearing that is upsetting for me, it's very sad, but I try to help her figure out how to navigate that. Not to mention her relationship with her husband has changed, incredibly, as he's aged and his capacity to care for her has diminished as well."

Participants also spoke of grief in terms of more ambiguous grief—powerfully present, yet not as readily identified:

> "I think about a client I have who I would say has a lot of grief, but it's kind of an ambiguous experience in that her husband has become increasingly disabled over the course of their marriage, and they're still fairly young. And this was her knight in shining armor…. [Over time] I felt able to kind of say: 'This is loss. This is grief. In as much as this isn't the person that you married. This isn't the person who used to take care of you. And you're sad and you're disappointed and you don't want to hurt him and you don't want to sound selfish.'"

Theme 1B: Centrality of grief to therapy. *Most* participants expressed that they saw grief as present in—indeed, central to—much of their work. This was seen in participants' description of grief as a universal experience—part of the human condition—experienced by all human beings in time, therapist and client alike. As such, and in line with their expansive understanding of the grief construct, participants saw grief to be central to much therapy work. As one participant expressed: "Whoever you're talking to--and I don't care if it's even not your client--*every*body has lost something. So are we all not grieving in one way or another?"

Another participant expressed a similar sentiment, noting how she has come to see grief concerns throughout her work:

> "I can identify something with every single client I see that I would describe as some form of grief.… What's shifted over time is that it's not something that I only think about if a client brings up 'Oh, this person in my life died.' Or thinking about grief as related to death-- the death of a loved one or something kind of traditionally connected to grief. I think so much more broadly about grief and loss.

Subtheme: Transition and grief through a developmental lens, vital to growth.

Within this theme of centrality of grief to therapy, *half* of the participants spoke directly to how they saw grief in terms of development and growth, and therefore core to the therapeutic process. As one participant explained, human development can be understood "through the lens of transition and growth, and that involves loss." She said that loss can be seen in such ways as "if you're transitioning from one phase of life into another, or in the particulars of job changes or partner changes." Another participant described recognizing how grief "changes who a person is," and that "it's one of the things that contributes to a person's evolving developmental self." She explained elsewhere how grief has become a central way in which she assesses client's developmental experience:

> "I am aware that I probably have many lenses that I use to try to understand or get to know a client through, and grief has probably become one of them…What have been this person's experiences with grief? It may not be something--unlike some of those other things--it may not be something that I ask so directly, but it certainly is something I'm listening for."

As one participant noted, the therapist's role is often that of helping clients move forward through the painful uncertainties of loss and change.

> "It seems like a lot of the stuff we deal with is related to loss. Because one of the scariest parts for clients is change. When they come in--they're not coming in because things are working, they're coming in because things aren't

> working…Usually something's changed—they become destabilized. And they're fighting to get back, and I'm trying to help them move forward."

Another participant stressed the importance of the ability to grieve—viewing it as core to growth and development:

> "I believe that the capacity to grieve is at the center of all therapy, and when people have that ability to grieve, that's the good news. And that when somebody is in active grief, that is really rejuvinating and energizing to me as a therapist. What's difficult is when people can't grieve. And so I look at grief generically as a way of being in a healthy relationship with yourself. Your ability to grieve. Because if you can't, then your defense mechanisms come up to compensate in ways that start lopping off parts of the self and shutting down your relationship with all parts of yourself….
>
> "I don't tend to think of grief as having different categories or different complexities—though, it's true…I think of grief as a central core part—that ability to grieve [is central to emotional health]—with everyone I work with."

As she reflected on the interview, another participant expressed:

> "I certainly appreciate that grief counseling, grief work, grief therapy needs to have a discrete identity--or needs to be talked about that way. Yet as I've talked, I've been thinking, almost everything we do with growth and change has a dynamic of loss, change, hope that you need to honor…."

Theme 1C: Belief that one size doesn't fit all in grief: Remaining client-centered. Throughout *all* participant interviews, a clear theme emerged related to honoring the unique expression and timing of grief for individuals. This message revealed a client-centered approach among participants and a commitment to normalization of grief as a human experience. Participants' comments in this area appeared to react against societal messages about how quickly grief should progress or how grief should be expressed. Further, there appeared to be an implicit reaction against both the stage-theories of grief that widely persist in mainstream society and how many adults talk about getting through grief.

One participant acknowledged the many factors that may shape one's grief response.

> "Every client's story is unique and no two clients are the same in terms of their story about grief and loss and what they're going through. And so it's very important for me to be very open, very present, and to be respectful of the client's unique circumstances….
>
> [I've learned] that people are just so different in their responses to loss, and one size does not fit all. There are a lot of variables in people's responses to loss. Partly it might be their own constitution, their own personality. It could be circumstances. Or both. Circumstances, the nature of the loss, traumatic loss or long, lingering death. Relationship with the person, if it's person loss. So I am more and more appreciative [with more clinical and life experience] of all the different factors there are when a person comes in if it's a particular loss thing--or even if it isn't, it's something else but has a loss component. Lots of variables."

Similarly, another participant emphasized remaining client-centered in terms of understanding the client's unique experience of loss.

> "There's no right way of grieving. There's no formula. Everybody's different. There's no timeframe, where I think in our society there's this idea about so much time has passed, and so it should be resolved. It's really very, very unique for each person. And how people deal with grief varies--there's a whole range, maybe an infinite range of possible responses…That's about honoring the person's process about helping them discover what's right for them. And so much of that involves listening, and so little of that involves prescribing anything. So, that's not to say that I might not offer suggestions, or I might offer my own perspectives or insights, but never imposing these on clients who are experiencing grief and loss."

Participants spoke to the importance of monitoring their own assumptions of what a client's grief response might be, and being much more attuned to learning from the client directly. As one participant explained, "I don't assume how this is affecting someone. I listen for it." He added, "I will not assume that if a person has had a particular experience they must have a particular reaction." Another participant cautioned that clients may have very different reactions to a significant loss, based in part of the dynamics of the relationship with the person who has been lost:

> "…loss differs very clearly from "I lost my dad and he was my best friend and we loved each other so much" to the real ambiguous loss, where it's a conflicted relationship, and the person feels ambivalent where there was the love and there was also the hate or the anger….Just being there for wherever the client is at with their emotions and their cognitions about what they're experiencing."

Subtheme: No right timeline. Within this theme, *most* participants spoke of learning to trust the process of grief to unfold, both with their clients and in their own lives while, in turn, rejecting an arbitrary timeline. This flexible timetable related to a commitment they had learned to normalizing the grief process. As one participant explained:

> "One of the things that I think may be most helpful for patients is depathologizing [grief]. The people that come in thinking that because they're feeling these things, and it's been 6 weeks, that somehow they should be over it. And of course their family members don't want to see them in pain, so they're trying to say, 'C'mon now, let's do this, let's have fun.'…So, giving them permission to feel their feelings and to recognize that sometimes they will want to go out and do that, but at times, when they don't, that's okay too."

Similarly, another participant conveyed the importance of creating permission and space for grief within therapy, especially when clients feel societal expectation to be quickly done grieving.

> "[One of the things I've learned] is to really let them grieve… Give people time, as much time as they need, to feel bad, feel angry, feel like the world is picking on them. To just really go through the whole process. Because that's what works. At least, in my experience, that's what helps them."

This participant continued her thoughts by adding a significant caveat:

> "The challenge of that sometimes is insurance. You get to the questions of: What do you diagnose somebody [with]? And is it fair to give them a pathology diagnosis if it's a legitimate grief situation?"

This raised an important point—not mentioned by other participants—related to the practicalities and ethical considerations of insurance reimbursement when grief is one of the primary client concerns.

Another participant spoke from personal experience about the somewhat fluid nature of grief's timing and expression:

> "One thing that I sometimes talk to clients about with regard to grief and loss is that…there's no timetable, there's no right way of doing it, that the intensity and the persistence of the grief reaction do tend to diminish over time. We come to terms with the loss over time, but there's no time limit… the grief can come up at any time. And it can come up years later."

To this point, the participant drew from personal experience, when some ten years after the death of a parent, a visit to a familiar place from childhood unleashed a wave of emotion:

> "It just brought back all these memories of me and my dad, when I was a kid, and I just sat there and I bawled and I bawled. I was like, 'What the hell is going on? This is crazy'….I didn't realize that I was capable of expressing that much grief about the loss of my dad still. And that just showed me that, okay, these feelings are not gone. I still miss my dad. I was grieving for myself and my loss… As time progresses, we tend to make our peace with the loss, but…our conceptualization, that we get over things, is wrong."

Theme 1D: Recognizing context and complexity in grief. While there was a strong message of normalization of grief and a rejection of narrow expectations of how grief should be expressed or unfold over time, there was also a professionally informed awareness of potential grief complexities. *Most* participants spoke of needing to understand the context of the grief, such as whether a loss was experienced as traumatic and whether one had had the necessary supports to grieve.

Within this theme of context and complexity in grief, several participants spoke to the importance of thoughtful assessment when grief issues emerge within therapy. In the words of one participant:

> "I have to identify whether the grief is immediate or recent or how distant it is, and if it's distant, what may have either gotten in the way of them being able to move away from it or move on, or what might be bringing it up right now."

One participant offered a personal example related to this point about the resurfacing of a more distant grief. The participant observed from their own experience how a young child might not be equipped to grieve a profound loss, and only years later might be able to give intentional, renewed attention to the loss and its implications.

> "Grief can go underground. That was my personal experience. [As a young child] I seemed to get over my mom's death really quickly, but it wasn't until years later that I realized that I hadn't really dealt with it….A child can look like they're okay and that they've gotten over something, but then what happens is that years later the grief resurfaces and they realize that, no, I never really dealt with it. I thought I had. Or I thought I was fine."

The participant described that as a means for survival, one's grief may go underground for a time, yet may benefit from a supportive therapeutic environment years later.

Subtheme: Grief complicated by trauma. A subtheme to emerge pertained to complicated grief, which was referenced by *over half* the participants in terms of a traumatic component to the loss. One participant spoke of witnessing the intersection of trauma on grief, stating that "trauma—and the result of trauma—are really the enemy of appropriate grieving, or empowered grieving."

A few participants gave the example of grief that has gotten entangled with a sense of guilt, whether in an abstract or more tangible way. One participant offered concrete examples of this:

> "If the client was in part responsible for it [a death], then we have more of a convoluted [situation. It is] harder to get over that grief, because I drove the car, for example, and it killed my friend. Or I was drunk, or the gun went off when I knew I shouldn't be holding it…"

Another participant offered an example from clinical work of how complicated grief can impede healthy or successful grieving. Recalling a client who had experienced the death of a close family member, this participant spoke to the physical impact that can emerge from unresolved, complicated grief:

> "The [client's] body carried that pain and blame and sadness. The grief was contaminated with the self-blame, and so it went into the body and couldn't get metabolized and moved through. And so what happened was this cyclical reenactment: [the client] would [have a physiological response] every [season] around the time that [the client's loved one] died... Grief that isn't addressed and felt and metabolized will sink down—or, some other verb that we want to choose—and come back in a worse form.

This participant explained the potential role of therapy in helping 'metabolize' such complicated grief:

> I think that unresolved grief finds energy that's not available for the psyche and so it takes away the necessary vitality to keep living a full life. And so when you can go in and metabolize that grief, it releases what was bound to it, and then that energy is available for that person to live a more vital life."

Subtheme: Intersections with other therapeutic concerns. *Half* of the participants also addressed how a client's grief process might be impacted by other therapeutic or diagnostic concerns. One participant explained that the considerations of "…how to help clients with their own grieving process and how to get them through it" required "always being cognizant of what are the issues that I think are underlying, that might get them stuck in something, and trying to help them through it." As another participant explained, one must be able to distinguish between grief that might be

considered typical versus expressions of grief that might be indicative of a larger therapeutic issue keeping a client stuck in pain.

In as similar vein, another participant described seeking to honor that "everybody has a grieving process," while also recognizing when other therapeutic issues may be entangled in the grieving process—issues that may warrant a different therapeutic response. This participant gave an example related to an ongoing client who experienced a sudden loss:

> "I have somebody grieving the loss of her husband, I think that she's still in shock. She's not grieving how most people grieve. She isn't….And so I have to pay attention to the therapeutic issue that I was dealing with her before the loss, and at the same time, [attending to] how she's dealing with grieving, and then coming up with what's the best way to help her through this..."

Theme 1E: A hopeful lens: Beliefs about grief and grieving well. As participants spoke to their experience of encountering grief in their work, a theme emerged regarding beliefs about grief and grieving well. These clustered into three subthemes related to reframing grief, witnessing resilience in and through grief, and seeing potential and possibility in the process of grief.

Subtheme: Reframing grief. Nearly *half* of the participants shared examples of how they talk about grief with clients, honoring the grief process as something of purpose and value, not to be rushed through or avoided.

> "I think there are societal messages about 'I have to get over this.' I have to get over this grief and this mourning. That it's somehow unhealthy. And I think that one of the things I learned was giving clients permission to grieve and to mourn, and that was really helpful to them, and to me in terms of being a therapist. And one of the things I would tell them was that their grief and their mourning was a way of honoring the person that they had lost, or even the pet that they had lost. Just that idea that we don't grieve and mourn when we lose something that's unimportant to us. It's actually a way of honoring. And it's painful—yes, it's painful—but they're showing how important and how much they valued [what

> they lost]….And when clients hear that—it's surprising to me—it's a simple idea, but it has a profound effect. Like, 'Oh, wow, I never thought about it that way,' and 'Okay, so it's actually right for me to be grieving and feeling the loss so deeply.'"

Another participant spoke of using self-disclosure to invite a reframing of grief.

> "One of the things I tell them from my story…is that I came to the conclusion that the pain associated with grief was really the flip side of love, and in proportion. So if I loved the lost individual this much, that's about how much pain I'm going to experience when I'm feeling the pain. And that allowed me to interpret it in a very different way—in a positive way—and in a way that made me not necessarily want to avoid or get away from it. But I think it was a healing thing. And so I share that with folks."

Subtheme: Witnessing healing resilience: Transformative power of grief.

Nearly *half* of the participants spoke movingly of both experiencing and witnessing a transformative dimension to grief. One participant offered:

> "I say to my clients…that the human spirit fights toward health and wellness…Grief is a normal, natural part of life. We're continually changing. Most people…heal from grief, heal with grief."

She drew in part upon her own experiencing of this healing process:

> "And I really do like my life now, and that's—that's a huge change. I think of [the death of my child…], and I remember thinking initially: My life is spoiled. It's just a matter of living out the rest of the years. And that's not at all where I am now."

Another participant offered a hopeful perspective grown from seeing and experiencing transformation and growth through grief.

> "So often we just look at grief from the direction of going into it, and it is so hard. But if we look at it from the other side of it, I really can see where it has transformed—has the potential, at least, to transform people in some really amazing ways too. And it is one of the few human experiences we can all count on. So—I may be sounding almost too Buddhist—I really am a believer in learning from it and trying to not be afraid of it because of the aversive aspects."

Likewise, another participant recognized how her own trust of grief as transformative—a trust born from personal grief experience—grounds the hopefulness present in herself as instrument in the therapeutic process.

> "Having experienced grief, I know that it's transformative. I know that it hurts, I know that it can be scary….So I can bring those personal experiences in learning to that instrument….And I think that what we carry and what we bring influences that dyadic space."

Subtheme: Possibility and opportunity: Grieving allows for growth and change.

A final subtheme emerged as about *half* of the participants spoke of possibility and opportunity within the grief process to consider one's own humanity and finitude through a new lens.

> "Another aspect of my story that I tell people—particularly if they were there when a loved one died—I'll tell them, I was there when my mother died. I wasn't there when my father died. And how profound that was to be there at the other bookend of life….I also encourage folks—again, when the time is right—in one way or the other, to do what I call "thinking philosophically." We all live, we all die. And…this is normal. And it's normal to feel…[grief] when there's been a loss. Losing people is a part of life."

Another participant reflected on the unique period of time around death and the importance of leaning in with intentionality, when possible.

> "One insight from my personal life that has influenced my professional life is, you don't necessarily have a do-over when somebody passes away. You have that period, and you do the best you can. But sometimes it's really helpful to try to do the best you can, so that you can look back on that and feel positive about doing so."

In a similar vein, another participant spoke to the ways in which times of grief are ripe for meaningful development and growth, for clients who are able and ready to engage this:

> "Ultimately, life is transition and change, and so how a person negotiates that, I think, is one of the really big questions that grief can bring up. And some people can really go with that and some people not so much."

Another participant spoke of being strongly influenced by Victor Frankl's work, which she said helped her contextualize matters of life and death within an existentialist framework:

> "I do attribute a lot of the more aversive times in my own life to providing me with the parts of myself that I probably admire the most in myself. So, I think not running away—either personally or professionally—from things, even though they feel hard. And then I hold that and—don't necessarily say that at the moment—but I hold that belief for my client, that not only they'll get through this, but that these difficult times actually give us strengths and attributes that make us better in the long run."

Summary. The first superordinate theme emerged as participants drew upon both personal and clinical experience to give voice to an expansive understanding of grief and the ways they encounter this with clients. Participants normalized grief and loss as part of the human condition, which guided a person-centered approach. While participants reacted against cultural or professional scripts as to the timing or expression of grief, they also acknowledged factors that can add complexity to the experience and treatment of grief. Trust in the grieving process and beliefs about the potentially transformative power of grief were expressed.

Superordinate Theme 2: Navigating the Intersections of Personal and Professional Experience with Grief

A second superordinate theme to emerge from the qualitative data related to how participants navigated the intersections of their own loss and grief experiences with their work with client grief. Their professional understanding of and response to client grief was informed by a personal knowledge of grief, which stemmed from some combination

of one or more of these parts: earlier life experiences with loss, personal losses during one's years as a professional, or through other encounters with client grief.

Under the umbrella of this superordinate theme, five narrower themes emerged: Drawing upon personal grief experiences to inform the work; Feeling impacted by client grief; Use of intentional self-disclosure; Therapist's own tears in session; and Client death and dying. These themes naturally overlap, yet identifying and discussing them individually allows greater nuance and complexity.

Theme 2A: Drawing upon own personal grief experience to inform the work. While the interview protocol did not include any questions that explicitly asked about participant's own grief experience in their personal life, *all* participants referenced this in a general way, and *most* volunteered some particulars of one or more key personal grief and loss experiences.

Subtheme: Experiencing own significant personal grief while a therapist can make the work more complex. While several participants alluded to the impact of personal losses and grief that occurred during their professional years, *some* described this experience more directly. One participant described returning to work a few weeks after a significant personal loss. She recalled the clinical considerations present, such as whether to disclose the loss, and carefully monitoring own her own emotions.

> "So I probably went back after three weeks and—I was really aware that I was so *full* of emotions for myself, and afraid that that would overshadow whatever the client was bringing in, whatever they were talking about. So, *really* trying hard to keep that in check."

This participant continued:

> "It's difficult going through it, but I think about other really difficult times for myself personally, when I was also practicing, and I do think that I'm sometimes

> even better when I'm going through something difficult myself, as a practitioner. It just sort of cues up all your senses to this heightened [reality]….But it can be especially exhausting."

Another participant reflected on the extra considerations and challenges present when at once navigating one's own shifts and changes in personal life while also assisting clients in professional life. It is within those times, she offered,

> "…that I'm more challenged to find my own internal vibrancy. And then how am I going to move that into my work? Because I don't think you cannot be a central part of what you do, because you are the instrument. So, if I'm developmentally negotiating a shift, that can be pretty challenging….And then I keep working that edge, and then I move into a new place, which, I think, parallels what needs to happen with clients. So what challenges me is when I'm in one of those and more stuck than I want to be [in my personal life]."

As an example, she referenced the challenges present as a therapist when personally experiencing a change in worldview, a divorce, or the death of a parent. She recalled a particular time of transition and grief in her own life:

> "So there was a lot of upheaval [when I was in grief] because my sense of who I was as a person and who I was in the world... Everything was kind of up in the air. So that was a pretty tumultuous time. So when there are major shifts going on in me [it adds challenge to the work]. And I think if you're alive and awake you're going to have shifts going on. I'd be more worried if you weren't."

***Subtheme: Personal grief experience informs understanding and empathy*.** One key point *most* participants expressed related to how their own personal grief experience came to influence their therapy work, especially their ability to empathize and understand their clients' experience.

Some participants described how significant personal loss experience preceded—and to varying degrees informed—their path into this helping profession. For others (*half* the sample), personal grief experienced during their years as a clinician served to deepen

and expand their capacity to understand and experience empathy for client grief. As one participant shared:

> "[T]he first thing that came to mind was that…until I lost my parents I didn't really understand what it was like to lose your parents. I don't want to lose everything that is--I don't want to lose any of my children, I don't want to lose my spouse, I don't want to go through any of that, to be honest. [Losing my parents] profoundly changed my appreciation for what it's like to be in that kind of a situation. So, sitting with people--the level of understanding and being able to put myself in their position as well as I could, or try to imagine what it was like, altered significantly once I had [experienced similar loss]."

Another participant likewise offered:

> "As a young therapist I…was working with people who had lost a spouse or who had lost parents--and at that point I had not. And there wasn't that same degree of empathy that I could have for that process and those feelings until I experienced it myself.…. I don't think that as a novice therapist--an inexperienced therapist--I really had the depth of feeling and empathy for a patient until after I went through some losses of my own that were more significant. An awareness of my own process led to greater feeling *with* the patients that I was working with."

One participant shared how lived experience of a particularly unexpected, tragic personal loss served to sharpen her capacity to respond to clients grieving significant sudden loss.

> "I lost [one of my parents] suddenly to a car accident some years ago, which was profound. I've been through grief myself in other capacities, but that was definitely the most profound loss and a surprise loss. And—so that's been helpful with clients—particularly those who lose people unexpectedly through accidents."

***Subtheme: Personal grief experience informs therapy interventions*.** Over *half* of the participants reflected on ways in which they drew upon their personal experiences of grief to inform and guide their interventions with grieving clients. As one participant explained, his own self-reflection about past grief experiences helped illuminate potential directions to take with a client.

> "Part of it is getting very comfortable with the whole presenting concern of…'I've lost a parent who was everything to me,' or 'I've lost a relationship that was everything to me.' 'I can't stop crying about such-and-such.'…My heart goes out to people when they're in that space. It's that real. It's probably that I can identify with them—I've been there. And I've thought about what I may have gotten in the past that's been helpful to me, or I think about what would have been helpful, when I've been in those spaces in my own life."

One example this participant offered grew out of his own lived experience of a parent's funeral. He described how navigating the complexities and demands related to the cultural funeral rituals had been a challenge. That experience guided his attunement to this facet of clients' bereavement experience.

> Funerals can be very stressful, and so if clients want to talk about that, I'm more than open to hearing about that. And I also will ask questions about what was their experience of [such rituals]. I think that having gone through my own experiences, I always want to know how a client handled, for example, their parent's funeral.

This participant had found that providing a space to reflect on and explore the experience and potential challenge of such rituals could be meaningful to clients.

Along the same vein of how personal experience informed therapy interventions, one participant shared the example of how his own past experience with the death of his dog opened up an avenue to more deeply engage his client's fresh grief over the death of her dog.

> "Our dog of 14 years old died a number of years ago. And just Friday, one of my clients--her dog died. She had to euthanize her dog. So she was talking about the experience. And I was there with our dog when we euthanized… So I asked her questions about what it was like for her, and [it was as though] we were able to go right to the room. This is a person who's normally not very tearful, but she was very tearful. And I asked her, has she talked with other people about it, and she hadn't shared it at all…."

Theme 2B: Feeling impacted by client grief. *All* participants spoke generally of experiencing empathic attunement to a client's grief—feeling touched by a client's

emotions and experiencing a sense of care for the client—with *some* also commenting that they'd learned the difficult yet important task of not carrying client concerns and grief home with them. Yet there were times when participants were mindful of experiencing client grief more powerfully. For example, one participant acknowledged the sadness she felt when encountering certain clients' grief:

> "There are some grieving clients—certain clients, depending on the client, the length of time I've been with a client, and the kind of grief that they're doing—that you know that when you connect with that person, you're going to feel that sadness in your own heart.

It appeared that there were two kinds of scenarios in which participants especially felt the impact of client grief, shown in the two subthemes that follow.

Subtheme: When particularities of client grief touch one's own. *Most* participants referenced times when a source of client grief touched their own grief. For some participants, this was a shared bereavement experience—for example, therapist and client both having experienced the death of a parent or the death of a child. For other participants, this was another type of shared grief experience—such as the complexities of grief in a divorce, or the dimensions of grief and loss present when coming out as LGBT. Still others acknowledged that their client's grief could touch on their own anticipated or feared losses.

One participant offered:

> "My hardest grief cases have been clients who lost children. Because I have a child, and I think that's the thing I'm most afraid of. So those have been the hardest grief therapy cases that I've worked with--hardest on me."

This participant continued:

> "I do a lot of journaling and just checking in with myself, both when I'm [facilitating] therapy as well as not. Probably more so…when I know things are in

> particular touching on things for me. When I've had clients lose children, I know that's been hard on me and I'm thinking about that out of session sometimes. And putting myself in their shoes... So I have to do extra self-care for myself."

Another participant reflected on how client concerns have touched her in different ways at different stages of her life and career, most recently her own awareness of aging and mortality. She volunteered that seeing certain clients face painful medical issues have been particularly hard:

> "I was talking the other day [in my consultation group], getting some help, because as I get older, my clients get older, there's a lot more loss and change.… While I've been around a while, to find my centered place about that is a challenge. So, my good friends [in consultation] are helping me do some of that... For some reason I was stronger about it when I was younger."

Subtheme: When long-term clients experience grief. *Half* of the participants acknowledged times of feeling particularly saddened for and with the client. In the quotations that captured this dynamic, there was a unifying thread of having known the client over time, and it appeared that a key variable was that a strong therapeutic relationship had been established with the client.

One participant described the emotional impact felt when an ongoing client experienced sudden loss. A key variable was an established relationship with the client, while other variables of type of loss and immediacy of interaction with the client certainly contributed.

> "I've had a couple of clients who lost children. One that comes to mind is a parent that I worked with very longer term, and I'd met the son on several occasions--we talked a lot about the son in our therapy sessions. And he committed suicide… And that's definitely been defining and stayed with me because of so many things: I was very close to that client, I'd met the person who committed, I was one of the client's very first calls [after]… learning about it."

Another participant reflected on the importance of distinguishing between the client's grief and one's own, when the therapist feels grief about the client's circumstances:

> "I have had some people who had had some horrible things happen. Either acutely like [a client's loved one being murdered], or these folks now who are losing their physical [capacities]. Now I have two or three clients who are in very mild dementia, early dementia stuff. The piece I have to really stay on top of is to make sure we're working with *their* grief about it. Especially when I worked with the client for five-ten years..."

Along this vein of distinguishing the client's grief from one's own, another participant related an experience, early in her career, of feeling strongly touched by her young adult client's intense grief emotions when the client's sibling unexpectedly died.

> "It was the [client's]…raw despair and sadness. I'd been with people in that before in my life, but not as a therapist. And I was so sad. And I remember sitting in my office [after the session] and crying, and having one of my colleagues check in on me. I almost felt embarrassed by how intensely I was feeling it. But I just had this sense, like: 'I want to be there for her [the client]. And she has to go through this...'"

Theme 2C: Purposeful use of self-disclosure. Approximately *half* of the participants described navigating decisions related to self-disclosure, of their own grief experience, to clients. There was a range of perspectives and experience in terms of the degree to which participants chose to self-disclose and the reasons that guided this.

The following quote illuminates some of the multiple considerations that come into play when weighing use of self-disclosure, including the clinical purpose of the disclosure.

> "With patients experiencing grief, I think it's almost impossible not to tap into your own experiences with loss of some kind. And that's not a bad thing. It helps with empathy, I believe. I think the important part is kind of knowing when to use your own experience and when to share, maybe, something similar—and when to back off….It's a matter of clinical judgment, but it's also a matter of experience.

> Because I'll share myself, but I won't do it if I think it's not going to be productive for the patient."

At times intentional self-disclosure was used to normalize—or to depathologize—grief. As one participant explained:

> "My own experience is salient, and seems to be a good story to tell to people. It tells them that they're not alone, and…even your therapist had certain feelings. You know, even your therapist thought about it and tried to come up with some understanding so he could live with what had happened."

The same participant described an illustrative or instructive purpose to self-disclosure:

> "I often share my own experience. I lost my parents when I was [in my earlier adulthood], and they died [in close succession]. It was pretty hard. But I'm a fairly thoughtful person and reflective person and…so I put some things together for myself from that experience and…I almost always share that with my patients…."

Another participant described using self-disclosure as a means to offer a hopeful future outlook to parentally bereaved young adult clients:

> "It [use of self-disclosure] can be helpful, because I'm kind of giving them a future slant on things. I'm telling them about grief, now, almost 20 years later and what I feel like as opposed to the grief I experienced 3 years after the death."

The same participant offered that self-disclosure also permitted expression of understanding and built credibility:

> "I think in the case of grief it [self-disclosure] is actually an asset, because once you have a big loss like that, you're immediately removed from a place of innocence. And other people who have not been there, you don't know what they can possibly offer you unless they've gone through that. So, I felt like it [disclosing own bereavement experience] gave me an in with…the clients. And sharing my story, I think, helped. As long as I didn't keep telling it. I mean, I left enough room for them too--but I wanted them to know that on a personal level, I could understand."

Some participants reflected on the degree to which they chose to self-disclose, and the purpose behind this. One person suggested that in general, she takes a more

conservative approach to self-disclosure with clients, although with grieving clients she might do so more than with clients with other presenting concerns.

> "I do think there's a range of appropriate self-disclosure. I'm more on the 'don't disclose too much.' But with clients who are grieving, I often do share that I have significant loss in my life, although not the details."

Another participant noted her own trajectory from more to less disclosure over time, reflecting on the question of whom the disclosure served.

> "I used to do much more self-disclosure when my clients were talking about loss and grief, and that was my need, and I think I talked myself into believing it was good for them too. And I don't have the need to do that anymore. I think it's important to many people I see that I too have lost a child, or that I'm getting older as well, or that my sibling had cancer. But they don't need the whole story."

Just as intentionality about self-disclosure was expressed, intentionality around the boundaries and limits around self-disclosure was also addressed, illuminating necessary awareness of over-identification.

> "I guess I've been talking about how the personal and the professional seem to be intertwined, right? There's really no way to separate that. But I have to keep the professional [role] in mind, because that's the thing that keeps me from over-disclosing and keeps me from over-emoting and stealing people's therapy from them [*laughs*]—which I don't want to do. I've had enough therapy, I'm not going to do that. But I think it can be easy to do if you over-identify."

Other participants described a way of connecting with clients that communicated a degree of shared experience or knowledge, without expressly disclosing details from one's own life. One participant offered:

> "I work with a lot of older people. They sometimes leave the world of being healthy—if they don't have a chronic illness—to entering the medical maze of trying to figure out now what I can or can't do, what's my life going to be like, how has this inalterably changed me. They might have body parts that were removed, they might have body parts that have stopped functioning, they have to alter their life… I've had some issues medically, myself…I don't share that with them, but I'm able to actually ask them questions and empathize with their

> experience and say what it's like, so they can get a sense that I know what they're talking about. And I really find that they appreciate that as a gift."

Theme 2D: Therapist's own tears in session. An interrelated theme emerged as approximately *half* of the participants acknowledged that when present with client grief, their own tears have at times surfaced. As with self-disclosure, participants reflected on the place and appropriateness of their own tears in session. As a whole, participants expressed a willingness to show their tears as a genuine emotional response to grief, so long as this seemed to support rather than obstruct the client's process.

One participant described how the rare emergence of her own tears with a client grows when there is a particular sense of joining and empathy, particularly in the presence of undefended client emotion.

> "I do find that at times,…I may tear up with an individual. It doesn't happen all that often, but occasionally I do. And I feel fine about it. And it's usually in response to really raw pain… It feels very much like 'I'm in this with you.'"

Elsewhere in the interview she offered:

> When the client is right there with it, it's any kind of deep, real, authentic experience, where there aren't defenses. It is so profound sometimes. And that's when I feel the most emotion....that's when I often tear up. And I'm just there."

Another participant shared the following example of experiencing a personal response while maintaining a client-centered focus:

> "And as we were talking about the sadness related to the loss of his dad, I started becoming tearful, and he became tearful. And I thought, 'Here I am crying--but what the hell--I guess this is helpful.' I wasn't like pouring it out or anything--but I didn't hide it. I [acknowledged] it. I was tapping into what it was like when my parents had died. But I didn't want to take away from his experience, so I didn't talk about me, I let him talk about him."

Several participants conveyed a sense that there is a potential therapeutic value in allowing one's emotional response to be seen by the client. One participant spoke to this directly:

> "I will cry with clients. I will [also] express, in words, my genuine emotions in response. I will say things like, 'I'm really sorry that this is so painful for you.'…And I think it strengthens the relationship when I express myself genuinely with clients--for example, if I cry or allow some tears to flow--I think that strengthens the bond. Clients see that I really care about them, and that I'm moved by them. And they feel that they can express themselves more fully, because their counselor or therapist is responsive. I know not everybody would agree with that. But that's what I've learned for myself works."

Another participant spoke of allowing her own tears in session if she felt it might have therapeutic value for the client in terms of validating or modeling an appropriate emotional response. She found this to be particularly valuable for clients who struggled with emotions.

Participants' comments on the place of their own tears in session often included a caveat about modulating the extent of emotional expression, so as to keep client-centered in the process. The following quote highlights one participant's mindfulness of honoring this boundary.

> "I do tear up periodically. Maybe I've cried enough to wipe tears away 3 or 4 times in almost 30 years. And it's not that I don't feel the tears--but I think I've learned what's helpful and appropriate for clients, and what isn't."

Theme 2E: Client death and dying. One additional theme emerged from the interview data under this broader umbrella of navigating the intersections of personal and professional experience with grief. This theme had to do with participants' grief when their clients were dying or had died. Approximately *half* of the participants spoke about the ways in which they had been impacted by the death of clients. One participant spoke

at some length about her experiences with client death over the years, offered that these are the grief experiences that have profoundly and personally impacted her, and the details stand out in her memory. She spoke to the significance of being touched by these experiences with multiple conflicting emotions, saying: "Oh, why would they not [stay with me]? And I'm okay with that. If I can't get touched by these, then something's wrong, in my opinion. That's how I operate."

Subtheme: Working with terminally ill clients. *Some* participants spoke about the impact of working with terminally ill clients until their death. These experiences were both emotionally charged and brought added clinical and ethical decisions. One participant recalled honoring a client's request to continue therapy when hospitalized. Another participant recalled:

> "It was super hard, I think it was two years ago: Two really nifty, good clients had terminal illnesses. Both ended up dying. And one of my clients had twins who were born way too early—…[and one of the infants died]. I had all three of these things going on. And I remember being really weepy at that point…. One of those two people asked me while she was still alive if I would do a eulogy. [And I consulted and chose not to.]"

Another participant reflected the experience of working with clients as they navigated their terminal illness, describing these as "seminal" experiences that have stayed with her. She recalled needing to navigate "all dimensions of grief—their grief and my grief," and wondering "How do I do this as a therapist?" Considerations regarding release of information and the potential of speaking with family members had to be navigated. She recalls these to be challenging yet "amazing" experiences that "helped me grow."

Subtheme: Grieving sudden client death. Another dimension of this theme emerged as participants recalled unexpected news of client death. A handful of clients described needing to at once balance their own grief emotions at the death of a client while also maintaining a professional role. For example, participants described navigating professional contact and conversation with the deceased client's family members, while also experiencing their own grief at the death of the client. As another example, a participant recalled being at once fellow-griever and therapist amidst a therapy group when a group member died. She recalled receiving news just before the start of group that one of the members had died in a car accident.

> "And now I'm going into the group to deal with my loss—I've been working with him—and then the group's loss, and how do I manage that one?...We're all crying. But I [was walking the balance of] letting some of my grief come forth, but also holding a part of myself back, because my job was my job."

Also in the realm of unexpected news of the death of a client, two participants spoke of their experience of client suicide, and the complex questions and emotions that accompanied this. The first participant recalled this experience as one that has stayed with him over the years, an event that prompted his own wondering and questions.

> "As suicide does—it left me with a feeling of wondering what, if anything, I could have done differently. It was unanticipated. It was an overdose—and so some question of whether or not it was intentional…"

A second participant who spoke of client suicide did so within the context of describing current meaningful therapeutic work with a client around grief and depression--a client who had been suicidal in the past.

> "I have lost clients. And that's an awful, awful feeling. Yeah, that's a terrible, terrible feeling....I never want that to happen again. I realize I may not have control over that, to the extent that I do, but I never, ever want that to happen again. So I'll do anything I can to not have that. That was--That was horrible."

Summary. The second superordinate theme grew out of the interview data as participants navigated the intersections of personal and professional experience with grief. Put another way, this superordinate theme aimed to capture participants' exploration of what was *yours*, *mine*, and *ours* when working with client grief. The distinctions were not always clear-cut, as both therapist and client brought lived experienced of grief to the therapeutic endeavor.

Superordinate Theme Three: Role of Therapist in Working with Grief: An Evolving Understanding

The third superordinate theme seen in the interview data related to how participants understood their role when working with grieving clients. This theme had to do with how participants understood *how the helper helps* with grief. During the interviews, most participants spoke of their role with grief in distinct ways related to presence and action, which had crystalized as they gained clinical experience over time. Most participants offered that as novice practitioners, they had felt an anxious pull to do something to reduce the distress of client grief, perhaps parallel to the lay helper response of suggestions and advice. These participants described a powerful shift over the course of their professional experience, away from that pull to 'fix' and toward a greater commitment and comfort level with being more fully present to clients and their emotions. From that place of presence, participants could assess when to offer a more active or directive approach to a client in grief. As will be elaborated in the paragraphs that follow, the data under the umbrella of this superordinate theme were organized into four interrelated themes: Movement from 'fixing' to presence, Using self and the

therapeutic relationship, Being actively present with intense grief emotions, and Grief-focused interventions: Drawing upon theory.

Theme 3A: Movement from 'fixing' to presence. *Most* participants described a professional developmental trajectory that can be captured under movement from a pull to *'fix'* to a value of *being present*. Almost all spoke to this trajectory specifically in terms of encountering client grief, although it also appeared to parallel a broader professional development arc forged through intensely sitting with and discerning client growth over time.

One participant described this movement over time as a shift from an outcome focus to a process orientation. Recalling her early expectations of the counseling role, she explained:

> "I think I started out thinking that we'd come in, and people would present with issues and we'd help them get to resolution, and there'd be a fixing kind of aspect to that activity. And basically I've moved from being outcome oriented to being process oriented. That was accompanied by a different belief and philosophy about what the nature of [therapy] was….—that affected how I thought about working with clients."

Another participant described this shift in terms of a trajectory toward *less is more*. He offered that a sense of professional confidence, grown over time, empowers this presence-focus.

> "I think that's another thing that's changed…[in] my therapy overall and…for grief. I don't worry as much about me as much as I just worry about them. One of the things I've had to tell myself is that half the battle is just being present. All I have to do is be present. Just sit down and shut up and listen to the client! [*laughs*] And let them talk! So it's like a *less is more* kind of thing. And interestingly enough it seems like one has to be confident enough to know how to do that, to be able to keep their mouth shut and listen and be present."

Continuing in this vein, this participant similarly described this shift away from a more prescriptive or didactic role—what he called an "expert role"—toward engagement as a fellow human being, including use of self-disclosure in a joining capacity.

> "I started off very fresh, like with theory and what I studied from books and the research…. And then over the years I keep disclosing a little more. I feel like I'm just allowing myself to be a fellow human being more so than the expert. And in the case of grief—that really brings it out especially, because there I'm relating to somebody as a fellow human being who's also suffered, rather than being an expert because of something I read as opposed to experience."

Likewise, another participant described a shift away from a more didactic role toward that of presence, bearing witness to the client's wisdom and experience.

> "Maybe the teacher part of me initially was stronger than it is now. It's more about bearing witness. And them knowing that they're saying something that they didn't know they knew, or they hadn't said before. Where in the earlier days, I remember—my school teacher–self had file-drawers full of handouts. And now it all fits in a basket....[*laughs*]"

Using similar language to quotes above, another participant described his role with grieving clients as that of "witness" and "co-explorer." He described a shift away from feeling anxious toward a greater comfort level with the emotional distress of grief.

> "As you gain experience you become more and more comfortable sitting with clients in their emotional distress and their pain in their grief and loss. And then you move away from that novice desire to fix things and into becoming a witness and a support and also a co-explorer."

Subtheme: Cultivating characteristics that support skillful work with grief. As participants conveyed a sense of this developmental trajectory, several participants identified qualities or characteristics that grew over time to allow this shift away from an intense urge to reduce client emotional pain toward a capacity to be present. One participant spoke of the importance of *humility*—a willingness to not have answers.

> "I am supposed to facilitate an experience for you. I'm not supposed to sit here and tell you how much I know, and that if you just listen to me, everything is going to be all right. So, the irony is that as I've grown professionally, I've become more humble. And it's actually that humility that allows me to be a better helper than if I was approaching somebody as if I had the answers."

Another participant described the importance of *patience* with the process—a quality she felt had grown over time, born out of sitting with many grieving clients.

> "What has changed? I'm more patient. I'm more patient with someone's process. That's what I've learned. To be more patient with them…. I realize that I have a bigger perspective. I've just seen so many people grieving…
>
> And they can do incomplete grieving, and that's okay too. They might never resolve their grief, and that's their walk. I can only be the part of their journey that they allow me to be a part of. So, I think when you've experienced a lot of clients, you realize that it's all different for people. So, I'm not as wrapped around the axle."

Another participant spoke of the importance of having *trust* for both client and self—trust in clients' resilience and trust in the value of what the practitioner offers through presence:

> "*Trusting the client can find a way*. I'm kind of Type A. I talk a lot. I like to fix things. So one of the growth edges for me all along has been to trust that even with people who are in awful situations—and it's coming up again now, with these folks who are having probably permanent, sometimes terminal, medical problems. *I don't have to fix it*. They will find a way in their lives. I can certainly help, but sometimes it's a matter of being there…trusting that we'll both be okay."

The importance of tolerating *ambiguity* was highlighted by another participant, who spoke about not needing to have an answer or solution in midst of bereavement grief.

> "I've also learned that…when there's not going to be an easy answer to give somebody, or a problem to be solved, it's me going to the things that I've learned about those places in life—and not looking for an answer, but being comfortable in the ambiguity. And that's how I can best be with somebody who's facing one of those dark times for themselves."

Theme 3B: Using self and the therapeutic relationship. As participants reflected on their therapeutic role when sitting with grieving clients, a theme emerged in *most* interviews related to use of self and the therapeutic relationship as vehicles for connection and healing. One participant spoke to the *self as instrument* in the therapeutic relationship:

> "This field is so unique in that you are the instrument—your own consciousness, your own ability to be in relationship to your own emotions and your sense of self.…There's a lot of pressure to keep current with self…
>
> I think it's keeping our ability to be fully present emotionally, because that's half the equation that's being brought to bear on the task."

Some participants spoke to a sense of grief's isolation and pointed to the healing potential within connection and therapeutic presence. In one participant's words:

> "…when you don't have any solutions it feels very isolating, so to be able to talk to somebody in that situation is healing, but not healing in the way that we're accustomed to thinking of healing in the sense of how a doctor heals a patient through medicine with pills or something. And so grief brings up that unique aspect of therapy and counseling…in that we really are just sitting with somebody and looking into the void together."

Along a similar vein, another participant offered:

> "It's so much more than words. And that the willingness to sit with somebody and being open to their energy and trying to put my whole self with them is going to be far more impactful to both of us. So I think trying less hard—even though I still look for the correct words—trying less hard, and knowing that if there's a way I can connect with the client, words will be secondary."

As seen in the second superordinate theme, many participants spoke of utilizing self-disclosure and expression of their own emotions—in moderation—as purposeful interventions with grieving clients. As examples in that section demonstrated, such disclosures were used for varying purposes: to communicate a deeper understanding, to build credibility, to model a hopeful future, and to convey an instructive message grown

from personal understanding. Emotional expression through allowing occasional tears—while boundaried—was understood to strengthen the therapeutic bond in terms of conveying understanding, empathy, and responsiveness. One participant offered this comment about his decision to self-disclose a shared loss: "[O]ne of the scariest things when you're grieving is to be alone. So, I hope to help them feel like they're not alone…."

Theme 3C: Being actively present with intense grief emotions. Many participants expressed that this act of presence rather than fixing—*being* rather than *doing*—created therapeutic space for clients to experience the natural and appropriate emotions that accompany grief. *Most* participants spoke of the importance of cultivating presence in the face of grief emotions, accepting and trusting the appropriateness of intense grief when it emerges. As one participant said,

> "…it is natural and normal and right for clients to be feeling distress. Of course you feel distress when you've lost something that's important to you, or lost someone who's critically important to you."

Another participant expressed that staying present requires one to trust in its value, resisting an urge to ameliorate painful emotions too quickly.

> "…knowing that I'm not going to be able to take away that person's pain. That they need to be with it themselves. And I think that that's a lesson I have learned for myself: that other people are not going to take away my pain….Learning, hopefully (and will learn more over the years) to tolerate discomfort for myself, in myself. So it makes me more able to tolerate discomfort in other people… Of course I would wish that in some way I could ameliorate some of this distress for them, and I think I probably do to a certain extent by my presence…."

Another participant shared that his willingness to stay with intense emotions of grief grew over time, out of a belief that it helps the grief move through the client:

> "I don't care if the entire clinic hears somebody crying. And it doesn't frighten me in the same way [as before], because I realize that it's not my role to take it away.

> I don't have to *do* anything other than be with them through that process. And I think that's obviously the most helpful thing."

Similarly, one participant described what it is that helps her stay present with intense emotion:

> "I think because I'm not afraid of it…Having such great respect and awe for how difficult it is, but knowing that there is another place that you end up. You don't *stay* in that amount of raw pain. It makes me not afraid to join somebody when they're there."

One participant recalled a defining moment that epitomized for him the importance of recognizing when to get out of the way and let a grieving client fully express emotion.

> "And I'll never forget the time she just cried…a primal cry. The most intense grief reaction I ever saw. And I just sat there, and she just let it out. I remember thinking, Wow, this is really powerful, but I'm just going to let her do it, because she has to do it….If you can sit down with somebody and witness something so viscerally painful that it's hard to look at, that's grief counseling at its deepest."

Subtheme: Utilizing own emotions: Within the context of cultivating active presence to clients' grief emotions, approximately *half* of the participants spoke of the importance of attuning to one's own emotions and energy. One participant described using her own energy or emotions as a gauge of what's happening in session. She made a distinction between feeling energized by grief moving toward healing, versus the challenge of staying with grief that is stuck in pain.

> "[Being with grief] is mostly an experience of… enlivening. It's healing, it's alive, it's movement, it's the opening of potential... So it's a positive feeling… I might differentiate between grief and pain—because when you're present for pain, that's a different experience…. You have to work harder at not getting caught up in the awfulness of it. Especially if it's basically trauma...and abuse. Staying really present for pain…takes a lot of work on the therapist's part....It's like watching somebody be hurt—you don't want to do that, you want to shy away from that. Yet, what's needed for the healing is full presence. So to me, that's a lot of work. The being present when it moves into grief? I see that very differently."

In a similar vein, another participant expressed the necessity of doing one's own emotions work so that one is able to stay present to the client, rather than backing away from intense pain:

> "So you have to have that willingness to go to that depth, because you can't take a client [somewhere] that you haven't gone yourself... [Some] clinicians will back off and … get cooler and put a nice little bow on it. Not because the person [client] is finished, but because the therapist doesn't want to go there. So you have to do your own work, you have to have your open heart, you have to have your open mind."

Another described revealing or expressing her own emotional process in order to help facilitate the client's emotional awareness, inviting and normalizing emotional expression.

> "For some clients there's the challenge of emotional resistance: 'I don't really want to feel that.' And I get that. But I feel when clients are really in the emotion of it, sometimes I'm aware of being really close to it too.
>
> Sometimes I am probably working at…a way of offering permission to allow themselves, if that's something that feels authentic for them…to have that."

One participant explained how she actively tunes in to the emotions and energy of the client, for understanding and connection.

> "I try to open myself up to their experience. So whether it's feeling it in my body, or really listening hard for what they're saying to me….I've allowed myself to genuinely feel feelings that were in the room and given myself permission to join in those, but I don't feel like I lost myself to the point of I wasn't watching over all the process in the room or having them be central."

Subtheme: Beyond sadness: Making room for complex grief emotions. A second subtheme grew out of *some* participants' reflections about the need at times to intentionally create space for clients' fuller expression of complex grief emotions—making room for emotions beyond sorrow, such anger or resentment. One participant

suggested that it can be easier for both client and therapist to recognize the sadness, at times, than emotions such as anger.

> "I have one patient...[who] was furious with her husband for dying. But until we got into her work, it wasn't really apparent how angry she was….Later we got into some of the grief work, and she was able to acknowledge that she was really angry with him for leaving her with all these problems."

Another participant expressed how making room for emotions has required awareness of her own privilege, and she recalled how that awareness equipped her to stay emotionally present when a client's grief was expressed with anger and resentment.

> "Being aware of my privilege has really helped me make room…for someone's grief about all kinds of things. Grief sometimes in terms of resentment; grief in terms of anger, too. Being able to let somebody have that side of their grief. I'm great with the tears…but being able to accept the rawness—sometimes the bitterness—that is part of their grief [is harder]….One day [a client] got mad at me, and she went off about all my privilege. She just laid it right out. Her partner was dying…[and] she was in a horrible place. So, I was able to [invite ways to] just bring it on, let herself go on. That's not easy."

One participant shared a grief-focused task he has offered clients, particularly those whom he felt might benefit from engaging more fully with the full range of their emotions, perhaps due to a complex relationship with the person who died:

> "Sometimes patients don't realize, I think, how profoundly they've been impacted by something….I will often times *encourage* them to get into a little bit more grieving than it sounds like they've done. And usually met with at least some hesitance at first….For example, one of the things I'll ask people to do is, when it really looks like that person is still dominating their life, I'll ask them to create a little shrine for that person and spend time….I think the work is about helping them express their grief, and their anger,…to the point where they say, 'I don't need that anymore. I'm ready to move on beyond it.'"

Another participant tuned in to her own range of emotions when present with a grieving client as a potential source for clinical insight and direction.

> "I've found, sometimes, where I might be mad where they're sad…. [I have to assess:] Am I feeling the anger because my client isn't wanting to feel her anger

> and she's actually feeling it, but is not expressing it, so I'm picking it up and expressing it? Or is this from my own feeling of I'm uncomfortable with being out of control…? So then I'm going to be angry, as a way to counter my own sense of helplessness."

Theme 3D: Grief-focused interventions: Drawing upon theory. It was consistently conveyed that therapeutic presence and emotional attunement were the foundation of therapy with client grief. Out of this foundation, active or guided interventions grew. *Most* participants spoke of more active therapeutic approaches they used with grieving clients. This theme captures some of the ways these were expressed.

Interventions depended on the client's distinct grieving needs and readiness. As one participant noted, "the grief work is on different levels. It could be helping them to get through the very next day, the next week, the funeral, first year,…subsequent anniversaries." For other clients, "grief work can encompass the bigger questions about life." As one participant stated, thoughtful clinical judgment must guide the use of appropriate interventions with clients: "I think we have to keep titrating what sort of interventions we bring based on our perception of where they are, what they can handle, what their language and worldview is. And that can change during therapy."

The following quote highlights some of the clinical considerations that must be weighed:

> "I have to identify whether the grief is immediate, recent or distant. If it's distant, what may have gotten in the way…of them being able to move away from it or move on, or what might be bringing it up right now. And is there something that I need to do to be helpful, or just be with them and share the pain of them experiencing loss?…My immediate concern is, is the pain going to be too much for them? Should I help alleviate the pain a little bit right now—would that be helpful?…So I need to make those judgments while we're doing this."

Such clinical judgments recognized the potential complexity of grief, as noted in the first superordinate theme, due to implications of trauma or the presence of other therapeutic concerns. Where a trauma history was more significant, use of an intervention such as EMDR (Eye Movement Desensitization and Reprocessing), offered one participant, was at times valuable.

Subtheme: Theory-based interventions. Within the interviews, *most* participants volunteered approaches they utilize to facilitate grief work. Some of these approaches were expressly identified by the participant as informed by broader counseling theories, while others were recognized by the researcher as reflecting specific grief counseling theories.

Several participants spoke in various ways about the importance of making a safe space for clients to tell their story and talk about who or what they were grieving. One participant explained how he developed this further by utilizing narrative theory-informed strategies to empower that story-telling.

> "I can think specifically of one client who I'd seen…early in my career—where we talked a lot about who his dad was, and what their relationship was… That was what the client needed and wanted to do in our sessions. And that taught me a lot about how that, in and of itself, was healing. And then talking about things like, 'What would your dad say to you now…if your dad were to see you experiencing all this grief?' So, knowing that this client had an internalized image of his father and also could 'channel' his father's thoughts and wise words, and that he still carried his father with him, and grieved the loss of his physical presence, but would always have the memories and also this internalized version of his father… What I could see was that the client really—and the client told me this—really benefited from coming in regularly and talking about his experiences with his father…using this narrative story-telling approach."

Within this example, one can recognize the continuing bonds theory of grief (Klass, Silervman, & Nickman, 1996), which, in contrast to earlier psychological theory,

emphasized formation of internal representations of the loved one. This theory was recognized in the comments of several participants, though was not directly named. For example, another participant described that her client work is informed by two tasks of grief:

> "First, to figure out how to bring that person…along with us through life…. Eventually we come to our own ideas of how we want to bring that loss along with us. And the second part…is to develop an ongoing relationship with the person, in this case, who died.… We talk to them, we remember them, journal about them, tell others about them."

In a similar vein, one participant told of his practice of inviting clients to share pictures of the person who died as an entry point for talking about client's experience and the relationship. He described his purpose for this as follows:

> "One of the most painful things about grief is that nobody can really relate to your loss, because they didn't have that connection, and the closest you could come to it is by talking about the connection.…The process of telling, describing that relationship brings that person back to life for just a moment….You're giving the person a chance to connect to that relationship which is not based on memory."

Another participant described a clinical approach that reflected the dual-process model of grief (Stroebe & Schut, 1999), which posits that adaptive coping benefits from a dynamic process of oscillation between a loss-focus and a restoration-focus:

> "Another thing that I learned was talking to clients about balancing between the intense grief and allowing themselves respite from grieving--that it was good for them to get a break once in a while, and how could they do that. And so that was moving away from *I have to fix it* to *Maybe there are ways to ease the burden*."

About *half* of the participants expressed an openness to engaging clients in the existential, or philosophical, aspects of grief if clients desired to do so. For some, this included attention to religious or spiritual beliefs or cultural influence that might be present—if these were found to be congruent with the client's worldview. Several

pointed to drawing on existential theory when working with grief. For example, one participant acknowledged creating space for the questions of "What do you do with pain and helplessness and the absurdity of this pain?"

Another participant noted that for some clients, the "bigger questions about life" often "spontaneously come up":

> "*Why we're here. When bad things happen to good people.* Those kinds of questions. *What's it all about, What's it all for?* Deeper knowing about and maybe "acceptance" (and I don't want to use this word too loosely, because that can be a loaded word). But I think this has to do with a larger philosophical spiritual frame. Ultimately, life is transition and change, and so how a person negotiates that, I think, is one of the really big questions that grief can bring up."

Subtheme: Flexibility with theoretical orientation when working with grief.

Some of the participants spoke of how their interventions and orientation in grief-focused therapy diverged to a degree from the theoretical orientation that generally informed their work. There was a certain flexibility to employ other approaches when it came to work with grief. For example, one participant explained:

> "With other kinds of presenting issues I might be more solution-focused or cognitive-behavioral, but with grief and loss I'm definitely more kind of a combination of what you would call narrative and client-centered and maybe existential. And there might be a little bit of…psychoed in there, but more in terms of giving clients information about what would be helpful to them... But definitely not as much cognitive-behavioral or solution-focused work as I might do with depression or anxiety….Because it brings up--especially with loss, with someone close dying--it brings up all these issues about the meaning of life, about what is the meaning of my own life."

Another participant offered:

> "I tend to…take grief issues out of the CBT stuff… I don't try to give them too much homework of, 'okay, fill in a mood log.' We know you're grieving and you're sad. So the homework would look different.…It's going to be processing and a matter of time….I have less of an agenda or thought in my mind of where things are going to go, session by session, with a grieving patient, than I do with somebody that's coming in for anxiety or depression."

Another participant described employing a different theoretical model when working with grieving clients than was his norm, guided by a more egalitarian-focused feminist model and existential theory that invites the meaning-making questions.

Summary. The third superordinate theme aimed to capture participants' descriptions of the role of the therapist when working with grieving clients. A strong theme to emerge from the interview data was that there had been a professional developmental shift from a pull to "*fix*" or *do something* to a focus on *being present* with client grief. The highlighted tasks of helping included use of the self in the therapeutic relationship, a commitment to deep engagement of emotions, and use of clinically and theoretically informed grief interventions.

Superordinate Theme Four: Factors Promoting Resilience when Working with Grief

The fourth overarching theme to emerge from the interview data related to factors that supported vitality when working with issues of grief. Under the umbrella of this superordinate theme, three narrower themes emerged: Energized by the integration of the personal and professional selves, Practices in personal life supporting resilience, and Practices in professional life supporting resilience.

As participants described their experience of encountering client grief, *most* held together a tension of opposites, describing this work as at once challenging and meaningful, at once exhausting and energizing. The paradox can be seen in the following participant quote:

> "[The times working with grieving clients] have probably been some of the most impactful and difficult yet rewarding therapeutic times… Reaching into my heart

> and using everything I have as a therapist to try to sit with a client in what I think is one of the most painful experiences of being human…It uses the most of me personally and professionally. It has challenged me…it's honored me... I felt very privileged to be able to share in somebody's pain, and sometimes pain that transcends words."

Another participant who has worked extensively with issues of client grief offered:

> "I don't think I've ever regretted--being what I am or doing what I do. Periodically it's heavy and it's hard, and I'm honored to be chosen to hear those stories and sit with somebody who's struggling."

A third participant reflected on the energy present when a client is in the midst of productive, healing grief—a distinction this participant made compared to unchanging, stuck-in-pain grief:

> "When somebody is actively grieving—as opposed to stuck in pain—….it's extremely energizing. It's very alive energy in the room, and the time flies… It isn't exhausting. You don't leave a session where somebody's been grieving and you feel drained. You feel drained when you've been doing 'war' with the defenses or being a very present witness to a lot of pain."

Some participants conveyed the message that working with issues of client grief stood out as uniquely meaningful among their client work, in part due to the salience and significance of grief work in these participants' own personal experiences of loss.

As a whole, participants did not speak of burnout with grief, although *some* acknowledged this may be in part due to the diversity of presenting concerns among their clinical practice. Participants acknowledged that burnout certainly can happen in the work generally—and *some* seemed to speak to this more personally. As will be made evident in this superordinate theme, participants mentioned the practices and perspective that they personally used to nurture resilience.

Theme 4A: Energized by the integration of the personal and professional selves. A key theme to emerge within this superordinate theme pertained to the integration of the personal and professional selves. Whereas the next two themes relate to specific actions or practices participants took in their personal and professional lives in order to cultivate resilience, this theme relates to the fit between person and profession. Participants spoke of ways in which their resilience in this work grew from the profession being a natural fit with their personality, characteristics, interests, and history.

Approximately *half* of the participants spoke of the way in which the personal and professional cannot fully be pulled apart. As one participant put it: “the personal and the professional…are so hard to separate because they’re so entwined, because we’re the instrument.”

Subtheme: Personal characteristics that fit well with this work. As participants described what allowed them to maintain vitality in this work, *most* spoke about personality characteristics or traits that fit with this work. One participant described how he experienced work with client issues of grief and loss to be egosyntonic, or aligned with his lens on the world. This allowed him to feel energized by this work: “I don't find it draining….This is cool. I get paid to do this. And it seems to help people!”

Others likewise addressed how natural characteristics and personality features made a good fit with this profession, which in turn supported resilience. One participant shared:

> “One thing that happens whenever I take the Myers-Briggs…I always get [the description of] "very tender-hearted." So I think that's part of it, is being pretty tender-hearted at my core [*laughs*]. And so when people are in pain, I want to be there for them in the way that is the most helpful.”

In addition to making thoughtful, intentional life choices that support resilience in some of the emotional challenges of this profession, one participant attributed some of her resilience simply to having good genes, personal energy, and "a lot of psychological stamina." Another participant offered that she often found the human interactions of therapy to be energizing:

> "I'm pretty extroverted, so those exchanges are rejuvinating in many ways….I feel like the privilege of this position is you get to sit in the front row of the human psyche, and that's infinitely and eternally interesting, as far as I'm concerned. And that may move into philosophical things as well as psychological things. But if you can manage to show up and help facilitate the client showing up, it's infinitely interesting..."

This personal interest in the human experience and dynamics was consistently voiced as critical to supporting resilience.

Another participant spoke of having a hopeful quality and an ability to hold the painful places of human experience within a broader scheme of life. This was nurtured by a commitment to self-growth that grew out of significant experiences of loss in early adulthood—yet appeared to be a central characteristic that supported this participant's vitality.

> "I feel I'm a fairly hopeful person, generally speaking, which doesn't mean I negate the dark side. I wouldn't be doing this work if I did! [laughs]…I think it's really hard to do this kind of work if there isn't some kind of sense about how to place darkness that we all experience—and some people more than others—in the whole scheme of life."

Participants' ability to find a hopeful or accepting perspective on grief also supported resilience in this area, as noted within the discussion of the first superordinate theme.

Subtheme: Life experiences primed for this work. Approximately *half* of the participants spoke about ways in which the intersection of their life experiences and personality served to make this work a good fit. One participant referenced Alice Miller's (1990) "The Drama of the Gifted Child," as she resonated with the premise that early familiar relational dynamics primed certain natural helping skills in helping professionals, teaching them to be deeply tuned in to other's emotional response, and she noted the gifts and challenges of this. More specific to the area of grief, one participant offered the perspective that one's early experiences of difficulty and the process of responding or working through these may influence persons to seek out this profession. This participant wondered aloud about the degree to which this motivates those entering this profession:

> "There's some motivation--and also that whole interest in the healing process. I think about how losing my mom at an early age, and then having to work through that, and that's just one of the influences I think. So I think about early grief experiences maybe—or grief experiences in general—being a predisposing factor to people becoming helpers later."

Another participant observed that the lens through which he has seen the world fits well when working with issues of loss and grief:

> "I just seem to be built this way. I've always seen when things are moving. It's just the way I am. And I think part of it is—we self-select for this profession…. In my particular family, we had a lot of movement and a lot of change and a lot of unpredictable loss. And perhaps somebody else who does the same exact work I do—another therapist—might see it through a different lens. But for me, that's the way the world was structured [with unpredictable loss], and that's sort of the way I can see it. At least, that's the way the world makes sense to me."

Another reflected on how early experiences with family in terms of deaths of grandparents to whom she was particularly close were handled in positive ways by

mature adults in her family. She felt this set a stage for her at a young age about how grief might be addressed and handled, rather than shied away from.

Subtheme: Valuing the circular process between self and the work. *Some* participants reflected on how there was a mutual influence between self and the work, in which one not only brought energy and perspective to this work, but was also impacted by the work. One participant spoke to this is a particular way.

> "There's something about being as fully present as you can be to somebody else's grieving. When there are points of similarity between what that person is grieving and something that you have experienced—and especially if you're down deep in the early, developmental stuff—it really increases the compassion toward the self. That's of course a circular thing.…You can't have compassion for someone else without that circling back onto yourself.…Those are profound experiences."

Theme 4B: Resilience practices in personal life. A second key themes to emerge within this superordinate theme related to practices and commitments that participants undertook in their personal lives that supported resilience.

Subtheme: Cultivating self-growth. Most participants shared that actively engaging self-growth practices have been key to nurturing professional resilience, some of which were integral to their work with grief, specifically. *Over half* of the participants spoke directly of the importance of engaging in personal therapy. One participant described the interrelatedness of personal therapy to the work this participant does with clients:

> "…like many people who do this work, I too am in therapy. I find it really helpful, and I use it both as a therapeutic and a consultative way.…So that helps me know what it's like to talk with somebody about the experience of loss. And once again, I'm revisiting the loss of my parents…and how I had to navigate that. So I know what it was like to talk with my therapist about that, and then I know how difficult it was at a funeral or at a family gathering after the loss, and then what I did at the gathering and what I said about my parent and how emotional I was. And how scary it was, but also how good it felt."

Another participant reflected on how grief has surfaced at different times of her life, and that therapy has been an important avenue for understanding and working with it, which then permits resilience in working with clients in grief:

> "I think you have to do your own therapy work in order to get there…I've done my own therapy work.., tackled my own grief, many different [times]. And I'll continue on to have grief, so it's not just something that you just face [once]. It's throughout life. You'll keep on getting grief."

One participant described how self-reflective work permitted a greater acceptance of the realities of human experience, which deepened her capacity to be present to pain and grief:

> "My own self-exploration has really come down to working on my own wholeness. …Really working on wholeness is what has opened me up to all the imperfection and being accepting of that. Knowing that I really do want to be authentic and consistent and so the same rules apply to me as I apply to other people. Being able to know that as a whole person, there's dark and light and lots of grey, and that there's pain…It's what helps create the contrast to have joy. And so not needing to fear it, or avoid it, but just accepting it as part of what is life…."

Another participant described the importance of intentional self-growth practices—including therapy—as a means of keeping current with self, recognizing the person of the therapist to be a central variable in the therapy process.

> "It's pretty circular, because what I experienced with them influenced how I was working on those edges in myself, and then that in turn came back and influenced how I worked with them…This field is so unique in that you are the instrument—your own consciousness, your own ability to be in relationship to your own emotions and your sense of self. So there's a lot of pressure to keep current with self."

Subtheme: Cultivating reflective and spiritual practices. *Some* participants spoke to the importance of reflective practices such as mindfulness, meditation, and gratitude as key ways in which they nurtured resilience in the personal sphere, which then also impacted their professional work. As one participant explained:

> "I do a lot of my own spiritual practices. I meditate every day….I do a lot of journaling and just checking in with myself.…I think when there have been grief situations that are more closely tied to my own experiences of intense grief, I'm aware that those can get activated, and I'll probably be more intentional than even normal."

Cultivating a spiritual practice in the sense of religious practice or religious tradition was mentioned by a handful of participants. One described the ways this translated into work with clients.

> "I am a Quaker and I am part of a strong faith community. I don't impose any of that on individuals….Worshipping in silence…over the years has helped me to go more deeply within and to facilitate that in others if they're ready or want it. And so I think it provides a depth, and in that depth, a hope."

Another offered:

> "I definitely am aware that when I do grief work—I don't impose or sometimes even speak them--I use my own spiritual beliefs about grief and death… I work within the framework of what's true for the client. But I definitely am using, for myself, my own spiritual beliefs, which actually have some positive connotations with the death part of the grief.…But that does help me. It does come into play."

Another participant shared how her own spiritual practices have shifted over time—gradually moving away from the more structured, institutional church—and how this shift related to a profound experience of grief in her life. She described coming to embrace more personalized spiritual practices that nourish personal and professional resilience.

Subtheme: Cultivating a full personal life. In the realm of practices in personal life that supported professional resilience, another strong subtheme conveyed by *most* participants had to do with cultivating a full, meaningful, and healthy personal life. As one participant put it, "I have to have sort of a balance…that whole work-life balance concept. I've still got to do things that I just enjoy. I've got my life to live. Knowing that

I need to do that—just making sure that I do it." Another participant spoke of the importance of "really taking the responsibility to keep the rest of my life going in a nice way."

In that spirit, participants spoke of the importance of actively nurturing their personal relationships with family and friends. This included caring for the physical self—sleep, exercise, nutrition—"all the things that we would say for our clients to have." They shared about the importance of nurturing creative interests, trying out new activities, and keeping intellectually and socially engaged. As just two among many examples, one participant spoke of belonging to "a book club of women that are eager, invested in life, and busy and smart," and another participant mentioned the importance of being invested in community activities.

Theme 4C: Practices in professional life that support resilience. In addition to cultivating practices in personal life that supported professional resilience, another clear theme emerged around strategies in professional life that support vitality when working with client grief. Again, participants spoke of resilience in this area in a way that overlapped with their clinical work generally, although examples connected with the grief topic specifically.

Subtheme: Consultation: Not going it alone. *Most* (two-thirds) of the participants identified consultation as a primary means of maintaining professional vitality. Most of these—all in private practice settings—mentioned formal consultation groups, while others spoke more generally of consultation, and one participant spoke of the value of having a cofacilitator for a therapy group the participant led. There were

multiple reasons participants valued consultation. One participant described how it afforded a means for ongoing growth, which helps her stay engaged and interested in this work:

> "I do a lot of consulting for myself—consulting groups and I work with individual consultants around particular cases—and that's part of what keeps it so interesting. I believe that if I don't keep the instrument finely tuned, I don't have much to bring to the party."

Another participant described use of consultation groups for support and feedback around certain client cases as well as for networking in the field. "I always have someone I can call if I get shaky about something," she said. She also described how this colleague group served as a place for genuine feedback and normalization of experience when the work gets discouraging or when client concerns touch close to home:

> "It's another way that the consult groups helps because all of us were transparent enough to say where we got caught up with that, so you get the benefit of other people's experiences...."

Subtheme: Continued learning: Nurturing curiosity and interest. About *half* of the participants spoke of the importance of cultivating the curiosity and interest that brought them into this profession and developing this in new and sustaining ways. In one participant's words:

> "What's important when maintaining vitality is my curiosity needs to be alive and I need to be actively pursuing different ideas, talking with other people…The continuing ed thing is super important….I read a lot. I follow where my curiosity and my passion goes, and then I figure out how to work with that… If I'm alive with my curiosity and passion about human development and consciousness…, then I'm good to go. And when I'm not, then it's slogging through the day."

In a similar vein, another participant spoke about the importance of seeking out a new area of professional growth in order to keep a sense of vitality in the work. She recalled that as one area of professional specialization—that of working with death and

dying concerns—had started to feel to too narrow, she expanded her expertise and professional focus in ways that felt creative and energizing. For this participant, finding ways to incorporate the creative arts in her work "is another way that…I keep refreshed in this work," she said. "That creative process, getting out of the cognitive sphere," she explained, has been energizing and hopeful in her work with clients.

Another participant described deepening his training and expertise in a particular theoretical approach late in his career, a process that he described as energizing. He spoke of the importance of "having another set of tools to help people. We need to keep learning, obviously," he said. "That's been one of the things that's helped me maintain [vitality]."

Subtheme: Recognizing the reach and limits of one's role. Another clear message *most* participants voiced related to recognizing the scope of one's role and the limits of one's influence. One way this was expressed by *most* participants related to the importance of maintaining emotional boundaries in this work. As one participant noted,

> "One reason that I think that I've not gotten particularly burned out is that I've always remained clear that my patients' problems are theirs and not mine. So I always manage to maintain a little bit of distance, at the same time empathizing…But I don't expect of myself that I'm going to—what they call mirroring—where I'm going to feel just what they're feeling. Nor do I need to."

Another participant reflected on her attention over the years to balancing empathic attunement to client suffering while not taking on this pain in a personal way:

> "I don't want to say that I'm immune in any way to the pain that individuals are in, but I also don't go home at night often [thinking about it]. Once in a while, I will go home at night and it will be heavy on my heart, but for the most part I don't. That may be because, as I said, I've been working with it for so long. I don't think it's because I'm immune to the pain… To do a lot of this work—not just with grief—I have felt the need to really work on being really empathic with people

> and ‘in there,’ yet myself not take on the deep level of pain, certainly, that they may be experiencing.”

This same participant spoke of the importance of learning over time to have a balanced perspective on the reaches of one’s responsibility and influence:

> “[I’ve come to] more of an acceptance of myself and my own limitations about, realistically, what I can offer and how I can make change. Because the change, really, is certainly more with the client than anything, although I do think there are differences with certain therapeutic environments or with certain practitioners. But I think so much depends on the client. And the synergy. So there's something—the X factor—whatever that is, that brings about the change, which has something to do with me, but maybe not tons…. It's like a modesty, but it's good. It's not a self-deprecation, it's just a…good, realistic view of how helpers help.”

Another participant described returning to the awareness that in the therapy hour she may see a narrow, amplified view of clients’ distress, but this is only a piece of the picture.

> “I have to have some faith in the fact that my time with them in their grief or their pain or their loss is—not that it's only in here, but that the intensity of it in here is, by design, turned up. We turn that up. We focus in on it. And so I have to sometimes remind myself: they're going to be laughing and they're going to be crying but they're going to be having this whole life that I have to remember I'm often only seeing a part of. I have to have some faith in that being what it is, and that there's other people out there who are also part of what the support is.”

Subtheme: Practical considerations of schedule and caseload. About *half* of the participants spoke about practical considerations in terms of schedule and caseload that challenged or supported vitality. A handful of participants had moved to part-time clinical work as they approached retirement, and each voiced how helpful this was in terms of supportive professional-personal balance and vitality. Specific to the topic of working with issues of grief, *some* participants stated that the diversity of presenting concerns among their client case load perhaps mitigated the potential challenges or

burnout one might face were grief their primary specialty and focus of practice, and were a majority of their clients navigating intense grief. In addition to diversity of client caseload, several participants had some diversity in terms of their professional roles, and one directly spoke of finding an important balance of teaching and writing with clinical work.

Others spoke to navigating the rhythms of schedule. For example, one participant addressed balancing decisions in terms of the frequency of facilitating a grief group. Another acknowledged the practical reality of the isolating nature of this work, and the intentionality required to manage this when the schedule is particularly full.

> "I think that if I've scheduled too many people, and I don't have enough down time, or I'm not social enough… One of the things that I didn't anticipate when I was a student was how isolating the work is. And because I'm fairly extroverted, that was something to get used to. So, it takes a lot of energy. It's pretty isolating. If you're seeing too many clients and you don't have enough time, then the tendency is to isolate, because you don't have the energy to be social.

One participant spoke to the challenge that can emerge when a crisis of loss enters unexpectedly into an already-full client schedule:

> Because my schedule's planned so far in advance, and so, I'll have a super heavy week or two weeks in front of me, and then have an unexpected grief therapy… It's been challenging. In one part of my brain, I probably should change a few things and take it down a notch, but then I already have the obligations out there. And then there's that voice that says to just power through and you'll be okay. So, the schedule [is problematic]. And then not even having, or offering myself, flexibility to shift when an unexpected situation emerges in therapy.

Another participant addressed the importance of thoughtful pacing of one's workday when possible, to plan space between sessions that may be require more.

> The pacing… You've only got so much empathy…You know, you can only dredge it up so many times physiologically, and that gets really tiring. So that's a hard part. And the way I cope with that…: I try to schedule people so that there's different people coming in at different times with different issues. And if I know I

> have a really rough time, I kind of prepare for that. I look at my case load ahead of time, and I think of what issues might come up, and I just try to get prepared for it.

Subtheme: Honoring the boundary between work and home. *Most* participants addressed the importance of keeping a healthy boundary between work and home life, so as not to carry the emotional burden of the work home. Two participants reflected on intentional ways they made this demarcation between professional and personal space.

> "In those early days, when I was seeing mainly bereaved parents, I had a tape in my tape deck that I would play—and it was all about good old Lutheran singing that I had grown up with. And oftentimes I'd cry the whole way home. And it worked. I figured out a way to take grief and not bog down my husband and children at home."

Another participant described a ritual established over the years to clearly demarcate the transition from work to home.

> "I can leave here and I ride my bike to and from work... It doesn't matter what the weather is. I didn't do it as much when my kids were at home, because I needed to get there--but we still worked it out…. So I know I can get on my bike--and getting on my bike and being away from [it all] just is helpful. So I get to go outside and I love being outside…I always--to put the work behind me--I always change my clothes, I wash my hands and face--I have this whole little obsessive ritual that I do…and then I'm home. I move and then I'm there."

Summary. The fourth superordinate theme reflected participants' engagement of the topic of resilience in this dimension of their work. As they reflected on what permits and challenges vitality when working with grief, three themes rose to the surface. They spoke of the importance of an integration and fit between their personal and professional selves, such that these could not be fully discussed separately. Further, they reflected on the practices and strategies they take on in both the personal and professional realm to support resilience in this work.

Chapter 5

Discussion

The purpose of this study was to explore *experienced* psychologists' encounters with client grief *over time* in the profession. A qualitative phenomenological approach was taken for this inquiry, and the researcher conducted in-person interviews with twelve experienced psychologists. The participant sample was comprised of counseling psychologists who were active clinicians and who brought multiple years of clinical experience to bear on the topic. The research questions and interview protocol invited participants to reflect on their work over time with grieving clients. Interpretative Phenomenological Analysis methods were employed for data analysis, with the purpose of deriving themes from the interview data. This chapter will take a wide-angle view to summarize overall findings from the results, then will zoom in to discuss key findings with respect to relevant literature. Further, the chapter will address strengths and limitations of the study, offer recommendations for future research, and discuss implications for counseling training and practice.

Summary of Findings

Detailed results of the data analysis were presented in the previous chapter. These results corresponded with yet also extended beyond the original research questions, as the interview questions and ensuing conversations broadened and clarified the scope of inquiry. Following is an overview of the prominent findings, organized here in relationship to these research questions. After this synopsis, key findings will be discussed in greater depth and placed in conversation with the relevant research literature.

Research Question 1. The first research question cast a wide net in its inquiry of how experienced psychologists are impacted by recurrent close proximity to client's experiences of grief and loss. The emphasis in this first research question is that of *impact*—understood in terms of what *effect* or *influence* encounters with grief over time had on the clinician. Notable themes arose from the data in this regard. First among these was that participants' understandings of grief had evolved and expanded over time in this work. This more expansive understanding of grief was firstly in terms of depth, as participants' increased professional and personal experiences with grief over the years profoundly deepened their understanding and respect for grief. Further, this expansive understanding of grief grew in terms of breadth, as participants noted how they had come to witness layers of grief in terms of significant losses and transitions throughout life, and as such grief was seen to be salient to much of their work. All participants spoke in terms of bereavement grief—and the majority of examples were offered in this context—yet the conversation extended to include many kinds of grief.

Another prominent effect expressed by participants was that work with grieving clients challenged them to examine and integrate their own personal experiences of grief, as well as their fears of anticipated loss. Several participants spoke of how the use of intentional reflection about their personal experience allowed them to draw from a deep well of personal knowing for empathy and for direction in the work. Such reflection and integration was essential so as not to be guided unawares by personal reactions or countertransference.

To varying degrees, all participants conveyed that they had been impacted by their work in terms of feeling *touched by* client grief—whether by an experience of shared humanness with the client's grief; by feeling moved by the raw emotion and the resilience to which they bore witness; or by their own grief when their clients to whom they felt professional attachment experienced significant loss, terminal illness, or death. Participants recalled clients and their therapy experiences with the clients that stayed with them over the years. These were moments of acute learning, moments of feeling caught by surprise by own emotion, or moments of feeling humbled in the face of grief. Some participants reflected on times when their work with issues of grief compelled them to seek out additional consultation or dig deeper into self-reflective work, including the use of therapy.

To be clear, as participants spoke of the impact of this work, they did not describe it in terms of singular negative ways such as burnout or compassion fatigue. In fact, several participants expressed directly that they did not feel a negative effect from this dimension of their work, but rather they found it primarily to be powerful and meaningful. Almost in the same breath they described being both honored and challenged, energized and exhausted by this dimension of their work. This range seemed to correspond with the complexity of client grief—in terms of layers of trauma or other therapeutic or diagnostic concerns—as well as whether and to what degree client grief touched their own experience. As a whole, the positive sense of work with grief included a trust in and belief in the value of the grief process. It must also be noted that because grief was not an area of particular clinical focus and specialty for participants in this

study, they were not flooded with issues of intense grief in their work in the way that a grief-focused practice would be, a detail that some participants noted.

One further way in which participants were *impacted* by their work with client grief was that it prompted further learning and development as a clinician. They described learning over time to adapt their therapeutic approach to client grief concerns, deepening their understanding of how their primary theoretical orientation related to grief, and at times borrowing from other approaches for this work. Further, participants described having been motivated to seek new understanding about how best to be with and work with grief. At times this was by turning to the grief literature, other times this was through seeking consultation, and for others this included exploring creative approaches to work with grief. In other words, encounters with client grief at times prompted participants dig more fully into their professional learning.

Research Question 2. The second research question explored how experienced psychologists time and again opened themselves to and engaged this affective work with clients. The emphases within this question are on the phrase *time and again*—recognizing that years in this profession bring one into encounter after encounter with issues of client grief, even if this is not an area of specialty—and the word *affective*, in terms of recognizing that grief can at times be marked by intense emotion.

What was found was that in order to do this work well, time and again over the years, participants needed to do their own personal work around grief and loss. Through self-reflective practices, use of consultation, or engaging personal therapy, participants were committed to understanding their own experiences of grief and loss and recognizing

their own process of this. Participants spoke of how such personal work ultimately helped them ensure that their own needs did not get in the way of their client's process, but rather served to deepen empathy and understanding of client grief. Moreover, it helped them find ways of making meaning of grief in a way that permitted resilience and healing.

Second, in order to time and again work with grieving clients, participants also learned to shift from a *fixing,* or *doing,* orientation to a *presence,* or *being,* orientation. In short, participants described a shift from an early pull to shelter clients from pain—through anxious efforts to "fix" or offer solutions and guidance—toward a deeper trust in the value of therapeutic presence and process. This was understood to ultimately be of greater therapeutic benefit to the client, and it was also more sustainable for the participants over the years as they recognized the reach of their influence and responsibility.

In a related vein, participants spoke of the importance of learning to trust and value the expression of grief emotions. To repeatedly enter into encounters with grief, participants described needing to grow increasingly comfortable with and committed to staying present and attuned to a fuller, deeper expression of emotion. This required a belief in emotions ultimately being in service to healing. As these clinicians created a safe harbor for their clients' emotional expression, they in turn invited a deeper expression and attunement to these emotions.

Finally, an additional way in which participants time and again opened themselves to client grief was through finding a way of personally and professionally

coming to understand grief as a necessary and expected part of human experience and development. In various ways, they spoke of trusting in the power and potential of grief as a catalyst for healing and growth, and this conviction permitted them to stay with the range of affect that could arise.

Research Question 3. The final research question asked: *How do experienced psychologists maintain vitality when time and again engaging this relational work with clients experiencing loss?* The emphasis here is on the question of professional vitality. As noted above, participants conveyed that they did not as a whole experience burnout or fatigue when working with issues of client grief, but rather found it to be meaningful and energizing work, if also difficult to be present to human suffering. That said, participants were highly cognizant of the potential for depletion and fatigue within this caring profession, and were mindful of ways in which they could mitigate such fatigue as well as empower and enhance resilience in their work.

One key way they attended to vitality was by doing their own work around personal grief and loss, giving attentive care to their own experience so they could continue to also support others. Furthermore, participants described being active and intentional in their commitment to resilience practices. To borrow a phrase from Skovholt and Trotter-Mathison (2016), these participants described the importance of "assertive self-care." For example, in order to maintain vitality, participants described the need to recognize the scope and reach of their work. This required finding an important balance between respecting the vital role they contributed to the therapy process, while also recognizing the limits of their influence and responsibility. Consultation was highlighted

as a valuable way to monitor this balance, and several participants spoke of establishing and maintaining long-term consultation groups. Participants offered that maintaining vitality also required that they keep tapped into their broader sense of what nourishes and sustains them, both personally and professionally. This included cultivating a full, rich personal life, nurturing personal relationships, and pursuing enrichment and creative activities. Finally, to maintain vitality, these participants addressed attending to ways to make their profession a good fit for them: following their clinical interests, finding ways to nurture their curiosity, and establishing professional rhythms that energize rather than deplete.

Engaging Key Findings

Having provided a summary overview of the findings as they relate to the research questions, we key findings in greater depth, particularly as they relate to literature in the domains of both grief and therapist development.

An expansive understanding of grief, grown over time. First, one of the notable findings was that participants' descriptions revealed that their understanding of grief grew more expansive over time, both in terms of depth and scope. It was apparent throughout the interviews that with greater clinical experience (in terms of number of encounters with clients and their grief) and greater personal life experience (with grief and loss touching participants' lives in new ways), participants' awareness of grief expanded, and they increasingly saw grief present and salient throughout their work. Perhaps this may seem to be an obvious outgrowth of experience, and yet it is worth

examining more closely how and why experience is such a powerful teacher and how this relates to therapist development generally.

Clinical experience as teacher. In their interviews, several participants described how their understanding of grief deepened as they worked with grieving clients. In short, clients were a primary teacher, a prevalent theme in the therapist development literature (e.g., Ronnestad & Skovholt, 1992). Participants came to a new understanding of the breadth and the potential complexity of grief as they witnessed client grief, whether it was fresh grief as clients navigated immediate and unexpected losses, or old grief that continued to have hold on the client's life. Bereavement was at the heart of most examples offered, yet participants also spoke of how they had come to recognize and respond to profound grief in terms of other losses—loss of a dream, an anticipated future, a worldview, a community. In fact, several participants reflected on having come to appreciate grief in the abstract as a necessary and expected part of human development, with the capacity to grieve allowing one to keep developing and growing over the lifespan.

Personal experience as teacher. Participants' own grief experience was also a key factor in this gradually expanding view. Almost all participants described ways in which their understanding of grief deepened as they experienced significant grief in their own life. By personally living through profound times of substantial loss, they recognized and appreciated grief in a way they could not have otherwise. They personally knew how disorienting and significant loss could be, and they drew upon how it felt to live through such a time and come out the other side. Whether they chose to disclose their experience

to the client or not, participants brought their personal knowing to the therapeutic encounter and it impacted the dyadic space.

The therapist development literature is helpful here, as it consistently has shown the essential role of both clinical and personal experience influencing ongoing therapist development and competence. Orlinsky, Botermans, and Ronnestad (2001), for example, in a wide-scale, international, quantitative study of psychotherapist professional development, found that psychotherapists consistently identify clinical experience as the primary source of influence on their professional development. In that far-reaching study, personal experience was certainly also found to be influential, yet secondary. That hierarchy of influence seemed less apparent in the current study, as participants appeared to draw equally on both personal and clinical experience in terms of understanding grief, perhaps due to the shared humanness of grief.

Germane to the current sample of *experienced* therapists, Orlinsky and colleagues (2001) also noted that when findings were organized according to years of professional experience, personal life experience grew in terms of degree of influence among more seasoned professionals. Similarly, among Jennings and Skovholts' (1999) findings in their study of master therapists, it was noted that their participants progressively drew upon personal experience to inform clinical practice. The current study appears to align with these, finding it is not only years in the field but also the life experience and losses that come unbidden over years that together inform clinicians' work.

Skovholt and Starkey (2010) write of the "three legs of the practitioner's learning stool," asserting that optimal functioning as a counseling practitioner requires a firm

foundation in three domains: practice, research/theory, and personal life. As participants in the current study reflected aloud on their experience, *clinical* and *personal life* experience appeared to take precedence over formal academic learning about grief. There were few direct references within the interviews to grief-specific research, literature, and theory. This may partly be attributed to the fact that the researcher's questions naturally invited more extensive reflection about personal and clinical experience, and the participants responded in kind. Yet here, too, the therapist development literature is instructive. Orlinsky and colleagues (2001), in the study noted above, found that seasoned therapists in their sample squarely identified clinical and personal experience ahead of more formalized learning. Likewise, Ronnestad & Skovholt's (2016) qualitative findings highlighted that "interpersonal" encounters provided a meaningful catalyst for growth, over and above "impersonal" learning (p. 153). A participant quotation from the current study may illuminate this dynamic, as she emphasized the importance of "*lived* experience, not read-about experience." Regarding her own voracious reading and study, she explained: "I'm not sure it translates unless it gets embodied in some way. It translates intellectually as a discussion, but in terms of the energy that you bring to the container, I think it has to be lived."

A firm professional foundation. While participants rarely referenced the grief literature specifically in these interviews, their descriptions of their work with grief was grounded in the bedrock of their broader psychological training. This professional foundation and framework was evident in the ways they referenced complex assessment and conceptualization of grief (e.g., Jennings et al., 2016), recognition of the nuances of

grief's expression, and determination of appropriate therapeutic response. A repeated conviction expressed throughout the interviews related to the variability in grief's timeline and expression. This one-size-does-not-fit-all understanding of grief corresponded well to the research into trajectories of grief and variables in grief response (Bonanno et al., 2002, 2004), and participants brought their professional lens and assessment to bear on discerning what kind of therapeutic support might be most valuable. Their ability to assess clients' needs—whether an immediate focus on daily needs after loss, or a deeper focus in time on issues of meaning and purpose in the wake of loss—helped guide their clinical response. Furthermore, it appeared that participants' ability to situate issues of grief within a broader context of professional and theoretical understanding provided a sense of therapeutic direction, helped make meaning of the place of grief within their work, and ultimately supported professional resilience.

Grief within a framework of human development. These participants brought their psychological training to bear on their understandings of therapeutic work with grief. As noted above, for many participants the discipline's framework of human development helped guide a way of relating to grief that took a wide-angle view. Several participants came to understand grief through this human development lens, recognizing that adaptation to transition and change was integral to growth and development. This understanding included an awareness of factors that might support or challenge how a client weathers losses and grief, which corresponds with the variables highlighted in the grief literature (e.g., Bonnano et al. 2002; Lichtenthal et al. 2011; Boelen, 2012). For example, several participants referred to variables in a client's life experience and

personality development that might impact and add complexity to their response to grief. Awareness of these variables helped participants appropriately shape their therapeutic response to grief. These clinicians' understanding of factors of attachment (Bowlby, 1969; Ainsworth et al., 1978), for example, helped guide their conceptualization and response to their clients' needs. Their related professional understanding of trauma helped participants assess when a more intentional trauma-informed intervention was appropriate.

***An integrative theoretical approach*.** Participants described a sense of flexibility or ease with integrating other theoretical approaches into their own typical approach when working with grief. This appeared to grow out of the clinical experience, confidence, and integration of learning that comes only with time in the profession. They related an understanding of where to place grief within their theoretical framework, and how to respond in nuanced, integrative ways. For example, the handful of participants who typically were guided by a cognitive-behavioral approach or solution-focused approach spoke of stepping away from this when it came to issues of client grief, instead drawing upon other approaches they felt were more conducive to the situation. A narrative approach guided some participants, who appreciated the focus on storied expression of the loss, the emphasis on identity and values, and creative work with the internalized representation of the person who died (with respect to bereavement grief). Several described turning more to an existential theoretical approach to help engage the concerns of meaning and mortality that are so present to grief, while others expressly highlighted or indirectly conveyed a feminist theoretical influence, with its value of

collaboration and power-sharing. The latter particularly appeared to inform considerations of self-disclosure of the therapist's own experiences of grief.

Other participants, who operated from an attachment-based or psychodynamic approach, described ways in which this theoretical foundation helped guide their understanding of their client's grief. A multicultural, systems approach was conveyed by other participants who emphasized the importance of understanding the cultural, familial structures that might contribute to the client's resources or difficulties in their grief experience. Several participants made implicit references to an emotion-focused theory, as they spoke of trusting the healing potential within movement of emotions. Some thus spoke of intentionally inviting deeper attunement and expression of emotion for those clients who seemed cut off from an accurate experience of their deeper emotions.

Personal grief interwoven with clinical work. Another primary finding from this study related to how the personal interfaced with the professional when working with grief. Participants were not removed, neutral observers of client grief experience, but rather they carried their own personal history and knowing of grief into the therapeutic dyad. At times, participants said, their own grief emotions were naturally evoked when working with clients, whether personally moved in the face of raw client grief, or when their own history of loss was activated. This personal-professional dance was a pronounced theme in the data.

Participants emphasized the importance of self-awareness of this dynamic, and they worked with this personal-professional dance in multiple ways. A consistent theme throughout the interviews was that participants felt their personal knowledge of grief had

the capacity to deepen empathy and to inform their approach with clients. This perspective was corroborated by Hayes and colleagues' (2007) study of therapist-client dyads, which found that when therapists had reached a certain resolution of their own grief experience, client's perception of empathy was deepened, reflective of a "wounded healer" perspective. Conversely, Hayes and colleagues also found that when therapists were still in active bereavement grief, clients perceived a lesser degree of empathy.

Considerations related to therapist self-disclosure and emotional expression were evident, reflective of a pronounced theme in related literature (e.g., Tsai et al., 2006). Several participants shared ways in which they at times chose to bring a facet of their personal experience into the therapy room through purposeful yet boundaried self-disclosure. Others acknowledged feeling tears when they were particularly moved by witnessing their client's grief, or when that grief touched their own. Several participants expressed the conviction that genuine yet contained expression of these could have therapeutic value. Participants aimed to be consistently client-centered in their work—seeking to discern, for example, whether self-disclosure or emotional expression was beneficial for the client, or more a reflection of the participant's own need.

Participants also noted times when their own fears or anticipated losses felt illuminated or activated by client experience. For example, some of the more senior participants acknowledged that awareness of the losses of aging and awareness of mortality were increasingly present in their work as they worked with older adults and as they themselves aged, a dynamic highlighted elsewhere (e.g., Foster & Vacha-Haase, 2013; Trotter-Mathison et al., 2010). In a different way, another group of participants

noted how working with parents who have experienced the death of children was the hardest for them, as it tapped into a loss that they most deeply feared. In short, participants were attuned to moments when they felt a response to a client experience due to their own lived or anticipated experience.

Countertransference and the use of self. Such experiences of the intersections of the personal and professional, when working with grief in the helping professions, are prevalent in the related literature (e.g., Foster and Vacha-Haase, 2013; Kouriatis and Brown, 2013; O'Brien, 2011). A valuable way to consider this is through the lens of countertransference. To be clear, an understanding of countertransference has shifted and changed over time. Its use here is in line with Katz and Johnson (2016), who describe countertransference as to be expected, recognizing it to be an invaluable tool in the helping endeavor if the helping professional is self-reflective and tuned in to the dynamic. They describe countertransference as an "'abbreviation' for the totality of our responses to our work—emotional, cognitive, and behavioral—whether prompted by our patients, by the dynamics incumbent to our helping relationships, or by our own inevitable life experiences" (p. 128).

From this broad perspective of countertransference, one can see that participants were wisely attuned to the potentials and the risks dwelling at these intersections of the personal and the professional. As Katz asserted, countertransference can be "the basis for empathy, compassion, and a deeper understanding of both the patient's and the clinician's own processes" (p. 27), yet left unchecked, can also interfere with the therapy process. Participants were cognizant that one's own activated or unresolved grief might hinder

empathic attunement, a risk highlighted in Hayes and colleagues' (2007) study, noted above.

In the research interviews, participants reflected on these personal dynamics within their professional work in thoughtful and courageous ways. In so doing, they communicated the rich value and the ethical responsibility of self-awareness in this work. Participants communicated key ways they fostered this self-awareness both individually, such as through cultivating a mindfulness practice, and with others, such as through participants' use of therapy and professional consultation. Therapists' use of therapy has been well-documented in the professional development literature as valuable for professional learning and self-awareness (e.g., Goldfried, 2001; Orlinsky & Ronnestad, 2005), and was validated by several participants within this study.

Likewise, the use of peer consultation—or peer supervision—is well-supported in the literature, for both ethical practice and collegial support and resilience (Ronnestad & Skovholt, 2013). Such groups can provide valuable professional development activity that is believed to foster therapist connectedness and prevent burnout in this sometimes isolating work, generate professional growth through diversity of perspectives, and keep clinicians abreast of current research and practice in their profession (Bernard & Goodyear, 2009). Two-thirds of the participants in the current study spoke to the vital importance of utilizing peer consultation, which offered an avenue for processing clinical work and gaining outside perspective and counsel. Avenues for professional consultation are particularly important in this profession, where practitioners otherwise have few

outlets to process their reactions due to the ethical and legal commitment to confidentiality.

As Dwyer and colleagues (2012) and O'Brien (2011) note, consultation may be especially important when practitioners experience the death of clients, providing an avenue for therapists to acknowledge their own grief at the ending of the therapeutic relationship—whether it was a strong therapeutic bond or more complicated in nature. Doka's (1989) construct of "disenfranchised grief" is salient here, as professional consultation provides a space for participant experiences to be acknowledged, honored, and responded to, when professionals' grief may elsewhere not have room to be acknowledged due to confidentiality. Within this vein, a handful of participants genuinely expressed the significance and sorrow they experienced at the death of clients with whom they had closely worked.

The importance of timing: *Being* and *Doing*. Another central finding in this study is the importance of timing. These participants described an anxious pull, when novice practitioners, to *do* something to reduce client grief. This is perhaps parallel to the lay helper response of suggestions and advice (Skovholt & Ronnestad, 2013), and reflects a typical response among novice practitioners (Teyber & McClure, 2009). Participants recalled, early in their career, feeling compelled to offer an intervention that might shelter clients from the intense pain that can accompany grief. They described a powerful shift in this perspective as they gained experience within the profession—namely, an increasing trust that a more competent way is first about *being* with client, *staying* with the emotions and experience, and only later taking a more directive role when appropriate. As noted

previously, some research and professional literature suggest that clients, themselves, are the most powerful source of influence for practitioners' development (Orlinsky & Ronnestad, 2001; Ronnestad & Skovholt, 2013; Skovholt & McCarthy, 1988; Trotter-Mathison et al., 2010). Likewise, it seems that this awareness of the important nuances of timing grew directly from direct work with clients, with the apparent experience that such "fixing" efforts did not lead to better outcomes. In time, through significant lived experience of clinical practice, the research participants moved away from the novice's anxious pull to *do* or *offer* something when with a grieving client, instead trusting the process of grief and its emotions. As one participant put it, lived clinical experience facilitated a necessary shift from an *outcome* focus to a *process* focus in the work.

Abore and colleagues (2016), likewise contrasting the pull to *do* with the ability to *be* with emotional suffering, emphasize that a commitment to self-awareness allows the practitioner to stay present to client's grief. Such reflectivity, they offer,

> "open[s] the opportunity to both recognize our collective humanness and to increase our compassion in the face of suffering. If we can take time to invest in our own healing, we will be more able to sustain our abilities to 'be' with the experience of suffering rather than feeling compelled to 'do.' Staying close, being present, witnessing, and acknowledging our patients' suffering are the first steps to empowering them to recognize and hold on to glimmers of hope and change in their own inimitable ways" (p. 49).

Several participants suggested that it is countercultural to stay present with and be patient to grief. During the disorienting time of bereavement, the presence and support of

others can be a "lifeline" (Sullivan, 2013), yet there is often an anxious pull present within Western culture that urges the grieving individual to move beyond grief and return to active life and typical functioning. Clients themselves may expect that they should quickly push past grief and resume typical functioning. As clients' lifelines in personal life start taper to off as time goes on, the therapy hour can be a safe haven for genuine grief emotions to emerge, with the therapist offering the presence and witness of another human being to the significance of the loss. Several study participants highlighted the *aloneness* of grief, and asserted that a primary role of the therapist was to join and support the client at that time.

An emotion-focused perspective. Within this emphasis on the *being* aspect of the work in therapy, there was particular emphasis within the interviews on focused attention to emotion. Most participants emphasized the importance of staying close to emotion and honoring its unfolding. This was not a passive act but an active one—a concerted commitment to presence and focus on the emotions of grief. As several participants expressed in various ways, so much of the grief experience is beyond words and the cognitive realm, and there is particular power in attending to emotion.

It emerged from many of the interviews with these experienced therapists that active attending to emotions required trusting and valuing work with the client's emotions, trusting that their expression has adaptive potential. Several spoke to the potentially healing power of affect and the importance for intentionally creating space for this. Implicit was the belief in the power of affect to transform and to heal when it came to issue of grief. Many participants appeared to trust in the "power of the visceral

experience of emotion," and the potential transformation experienced "within an emotionally connected dyad" (Fosha, 2000, p. 2).

This requires tuning into one's own emotions, which the participants acknowledged by speaking of the personal-professional interface and their commitment to their own grief work. This was another area where the countertransference literature is helpful. As Abore (2016) points out, if one's own grief emotions are under the level of awareness, practitioners may inadvertently hold themselves at a distance and therefore be unable to recognize, understand, or connect with the client in their grief. In so doing, they may not be able to offer a safe holding space for their client's emotions. When this happens, clients remain isolated and alone in their grief. In fact, Abore and colleagues argue: "if we fear pain and anguish, and if we ignore feelings that are evidence of our own parallel suffering, we run the risk of denying these very feelings in our patients. This leads to isolation and further despair and cuts off any possibility for positive change." O'Brien (2013) likewise addresses this, cautioning the practitioner to be mindful of any inner pull to avoid grief's emotions, so as not to inadvertently silence the client's emotional expression.

Cultivating a meaningful way of relating to grief. The many thoughtful ways in which participants communicated a sense of respect for, or acceptance of, the place of grief stood out to the researcher. As one participant said, one has to come to know how to be with and where to place life's darkness, if one is to thrive in this work. This seems akin to the extensive research attention given to the place of meaning-making, or

meaning reconstruction, as important to a person's long-term well-being or resilience after a significant personal loss (Neimeyer & Sands, 2012).

Participants expressed this grounded and constructive perspective on grief in various ways. Several described learning to take a long view of where grief fits in to the human experience of development and growth. Recognizing grief as part of life, and therefore an integral part of their work as therapists, they came to relate to it in a way that allowed them to stay present to it with their clients. In such instances, an understanding of grief was woven into a broader lens of development and change, and the capacity to grieve well was described as enlivening and a hopeful opening for growth.

Participants also described learning to trust—through experience—that the intense depth of grief does not persist, but rather that one comes out on the other side of grief. Likewise, others described trusting in a transformative potential in grief, which empowers them in this work. Again, there was a necessary dimension of lived experience to the expression of this. Holding hope with a grieving client in a genuine way, participants conveyed, grew out of knowing of which they speak. In various ways, they spoke of trusting in the power and potential of grief as a catalyst to healing and growth, and this conviction permitted them to stay with the range of affect that could arise.

Some participants made reference to a spiritual understanding or philosophical worldview that helped them hold their understanding of grief and human suffering within a larger whole, which allowed them to relate to the mystery and ambiguity of grief in a helpful way. For most, this was not necessarily expressed within a formal religious framework, but rather as spiritual or secular framework of meaning that the participant

cultivated, such as through a mindfulness perspective. Cultivating this practice and perspective appeared central to participants' resilience, helping them to staying grounded and having perspective when present with deep grief. Several participants referenced the fact that at times bereavement grief opened the door to broader existential considerations with their clients, an invitation to the client to consider one's life values and commitment to living with intention. While not all grief work had this broader existential dimension—as clients' immediate needs and readiness were different—this "philosophical thinking" was at times a meaningful and energizing part of the work, and appeared to touch on the personal work participants needed to do within their own experiences of loss.

As the common factors literature has noted, hope and expectancy factors influence therapy outcome (Hubble et al., 2010). It would appear that the therapist's understanding of grief—with past clinical and personal experience as teachers—is brought into new encounters with grieving clients and can contribute to such factors. It appeared that in a similar way, participants' ability over time to personally make meaning of the role of grief helped them relate to suffering within their own and their clients' lives in a way that permitted professional resilience. Such perspective seems to have become known and embodied through the experience of grief and suffering, through one's own life experience and through bearing witness to client grief.

Strengths and Limitations, Recommendations, and Implications

As with any study, there are inherently both strengths and limitations, due to the sample size, time constraints, and even geographical location. These are detailed below,

along with the researcher's recommendations for additional research opportunities, as well as a view of implications from the current study.

Study strengths. Among the strengths of this qualitative study, first and foremost was the wealth of clinical and professional experience represented among the twelve psychologists who participated. As doctoral-level psychologists, this group had undertaken a significant commitment to the rigors of academic learning and had a depth of training experience. They had between 11 and 29 years of post-doctorate clinical experience, and on average had been licensed as psychologists for 22 years. With a wealth of professional and lived experience, these participants contributed unique and thoughtful perspectives to the topic at hand. While racial diversity was limited among this predominantly Caucasian sample, a range of ethnic and cultural diversity was represented among the group. Furthermore, it was a diverse sample in terms of gender, age, marital status, sexual orientation, and family and social relationships. There was also a wide spread of religious and spiritual perspectives and practice in the group, with varying degrees of impact. Furthermore—and uniquely salient to this study—there was diversity in terms of loss experience, which participants willingly shared and reflected on in their interviews.

Another strength of the study was its commitment to the qualitative process, with face-to-face interviews allowing for an in-depth exploration of the research topic. As a phenomenological study, the purpose was to explore the experience of relating professionally to the intimate human experience of grief. The researcher's sustained engagement in the phenomenological research process was a strength, as she engaged the

data and ideas in depth through conducting the interviews, transcribing the interviews verbatim, and personally analyzing the data across all interviews. Use of a research team for data analysis allowed for multiple perspectives, discussion, and consultation, which helped add complexity and rigor to the analysis and ensured that a systemic process was honored.

Study limitations. Some study limitations must also be acknowledged. For example, the participant sample all practiced within the same large metropolitan area in the Upper Midwest. This may have limited the cultural diversity of the group, although their locations of upbringing were far-reaching, both nationally and internationally. Furthermore, the participants were graduates of the same counseling psychology doctoral training program, which likely contributed a certain degree of shared institutional culture and training perspective. However, the participants' training period at that institution collectively spanned more than two decades, and the group had a diverse range of faculty, advisors, research interests, masters' degree institutions, and practicum and internship training settings. This diversity of training was evident in the range of clinical interests and theoretical orientation represented in the group. Nearly half of the sample brought previous professional experience, before becoming licensed psychologists, such as from the medical and educational fields, which added richness to their interviews.

While the above limitations are of note, it is also recognized that the aim of phenomenological inquiry is not on generalizability, and as such does not require a representative sampling approach. The primary criteria that guided the sampling method grew out of the aim to draw on the expertise of experienced psychologists who primarily

had a clinical focus throughout their careers. This grew out of the goal of the research question, which was to understand the experience of those who had worked with many clients over the years.

Another limitation is that this is a retrospective study, in the sense that the participants reflected on their work over time. While an eligibility criteria was that they were active practitioners—and several drew upon recent client work—the interview invited a retrospective view of their work. The lens through which they recalled their early clinical experience, therefore, may have been shaped by their present experience and perspective.

Research recommendations. A key feature of this study was its focus on the experience of established clinicians, selected for their longevity in the field and their ability to reflect on their professional experience over time, and in light of many client encounters. The findings grow from this long-range view of the work and reflect an arc of professional development over time. As a point of comparison, it would be valuable to conduct a similar study with novice or early-career professionals, exploring similarities and differences. For example, how do early-career psychologists describe their experience of sitting with client grief, and to what degree does it correspond with the current study's findings of an arc toward greater comfort level, trust, and patience when being present to client grief distress? Likewise, it would be valuable to explore how early-career psychologists describe the influences of learning that have shaped their understanding of grief. To what degree and in what way would they integrate personal

and clinical experience into their understanding of grief, and would there be more explicate expression of academic and training influences?

Were a related study to be conducted of practitioners across the span of experience, it would be valuable to more directly explore what professional avenues of training they have found to be most integral to their understandings of grief. For example, what sources have informed their academic knowledge of grief, and how do these relate to the clinical and personal sources of influences seen most predominantly in the current study?

Finally, the current study did not focus its aim on specialists in grief, but rather drew together a sample of psychologists with a more general clinical focus. It may be valuable to conduct a similar study with psycho-oncologists, psychologists who specialize in end-of-life care, or psychologists who specialize in bereavement and grief issues, to investigate similarities and differences. For example, because the current sample did not specialize in grief—and therefore did not see a preponderance of grieving clients—a handful of participants noted that they did not experience fatigue or distress from this dimension of their work, but generally found this work to be meaningful and satisfying. When grief and loss is a primary area of specialty, are the findings similar? How do such specialists describe the factors that permit them to time and again open themselves to encountering client grief, with particular attention to how they conceptualize and make meaning of grief? Further, is the intersection of the personal, clinical, and academic legs of the learning stool (Skovholt & Starkey, 2010) described similarly when grief and loss issues are a primary area of specialty?

Implications for training and practice. There are numerous implications for training and practice evident in this study. Perhaps most important is an appreciation of the long view of professional development, and a reminder of the value and necessity of this. Participants conveyed that their learning and understanding of grief evolved over time, within the dynamic intersection of personal life experience and clinical grief experience, overlaid with their valuable professional understandings of human development and trauma. A willingness to intentionally engage and reflect on these dynamic intersections over the course of professional development appeared central.

Furthermore, participants communicated the importance of fostering an active and engaged spirit of ongoing learning—professionally and personally—in order to thrive in this work. It appeared that this spirit of learning and growth permitted these practitioners to be open to an expanding and deepening understanding of grief, and helped them seek ongoing ways of making meaning of grief in both personal and professional ways.

The findings of this study profoundly highlighted the value of reflexivity when working with client grief. The importance of self-reflection and personal work with the therapist's own experience of grief was clear, particularly as participants navigated understanding the reaches of their own experience of grief, so as not to impose one's own process on clients. The findings normalize and validate the value of the professional's use of therapy for personal and professional growth, and support previous research in this regard. The findings additionally support as the importance of intentional self-reflective practices, such as mindfulness, to deepen one's self-understanding and awareness. Further, there was a strong acknowledgment of the multifaceted importance of

professional consultation in this work. Such consultation was intentional and long-term with the creation and sustenance of ongoing formal consultation groups, as well as at times more short-term and targeted when particular needs arose.

Finally, the findings highlighted that understandings of grief evolved over time and were central to the work. Because of this centrality, it is recommended that topics of death, dying, grief, and loss be discussed more fully within psychology practitioner and other mental health training programs, inviting trainees to explore and articulate one's cultural beliefs, personal experiences, and expectations related to grief and loss, as they will encounter these in the work. These early discussions can set the stage for a career-long evolving understanding of human grief.

The study's findings convey that throughout their careers, intentional use of professional consultation, relevant professional learning opportunities, and personal exploration are important for therapist self-understanding and professional resilience around matters of grief. Further, ongoing attention to matters of grief has bearing on one's ability to competently and effectively engage grief dimensions of clinical work, understood by these participants to be a central aspect of the work, particularly when seen within a human development lens. Taken together, a thoughtful understanding and engagement of issues of grief may ultimately impact therapist sustainability and retention within this profession, as well as effective client care. Furthermore, it was evident that the intersections of the personal and professional continue to emerge in new ways over the course of one's professional life, as the therapist's own grief experiences and aging occurs over time. These call for the professional's intentional commitment to exploration

of how this intersects with their clinical work, with awareness of the challenges and gifts present in this aspect of relationship-intensive work.

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Appendix A: Consent Statement

You are invited to participate in a qualitative research study entitled ***Encountering client grief: A phenomenological study of experienced psychologists.*** You were selected as a possible participant because of your years of experience as a practitioner working with clients. We ask that you read this consent form and ask any questions you may have before agreeing to complete the interview.
This study is being conducted by Jo Quanbeck, M.A., for her doctoral dissertation in the Counseling & Student Personnel Psychology program at the University of Minnesota. She is advised by Tom Skovholt, Ph.D., LP, at the University of Minnesota.

Background Information
Through interviews, this study will utilize qualitative methods to explore psychologists' experience of time and again encountering grieving clients. Specifically, this study investigates *how experienced psychologists have been impacted by recurrent close proximity to client's experiences of grief and loss; how they time and again open themselves to and engage this affective work; and how they maintain vitality while doing so.* Your input will be valuable in helping us explore the impact of this relational work on the therapist, over time, and may inform current and future therapists in the process of seeking professional resilience.
Procedures

If you agree to participate, you will be asked to respond to a brief demographic questionnaire and take part in an individual interview. The interview consists of open-ended questions and is expected to take approximately one hour. The interview will be audio-recorded and later transcribed by the researcher. Qualitative methods will then be used to analyze the data in order to derive themes across the researcher's multiple interviews on this topic.

Risks and Benefits of Participating
Potential risks: The risks of participation in this study are considered to be minimal. As with any conversation about personal experiences, however, there may be a risk of feeling discomfort in talking about your own lived experience. It is expected that the questions asked in this survey and interview are not more personal or invasive than those you may already have discussed in conversation with friends, family, or colleagues.
Benefits to participation: There are no direct benefits for you for participating in this research beyond having an opportunity to discuss and reflect on your experiences and an opportunity to contribute to knowledge that may benefit other therapists and those in training. You will be given a digital copy of the full five-chapter dissertation when completed.

Confidentiality

Please know that your participation in the interviews will be kept confidential. Likewise, any information you provide will be kept confidential. All identifying information will be removed from the transcript of the interview. Identifiers will be stored separately from data collected. Research records will be stored securely and only the research team will have access to the records. If you choose to stop your participation during the interview phase of the study, all information you have provided will be immediately deleted. In the dissertation or in any report we might publish related to this study, we will not include any information or quotations that would make it possible to identify you as a participant.

Voluntary Nature of the Study

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota, the researcher, or her advisor. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

Contacts and Questions

The researcher conducting this study is Jo Quanbeck, M.A. If you have questions after the interview, you are encouraged to contact her at [telephone number], quan0065@umn.edu, or her advisor Dr. Tom Skovholt at [telephone number], skovh001@umn.edu.

If you have any questions or concerns regarding the study and would like to talk to someone other than the researchers, you are encouraged to contact the Research Subjects' Advocate line, D528 Mayo, 420 Delaware Street S.E., Minneapolis, Minnesota 55455; telephone 612-625-1650.

You will be given a copy of this information to keep for your records.

Participant Certification

I have read the above information. I have had the opportunity to ask questions and have received answers. By completing the demographic questionnaire, I agree to take part in the interview as a research participant in this study.

Appendix B: Letter to Prospective Participants

February 23, 2017

Dear Dr. XXX:

I am a doctoral candidate in Counseling and Student Personnel Psychology (CSPP) and an advisee of Tom Skovholt, Ph.D., LP. I am reaching out to you, an experienced psychologist in the metro area, as I am completing a dissertation study that would benefit from your voice and perspective. I hope you will consider sharing of your experience.

I am conducting a qualitative study on the topic of psychologists' experiences of working with client concerns of grief and loss over time in the profession. From your years of clinical experience, you know how often issues of loss and grief are central to client concerns. This study explores the impact and meaning of this recurrent experience for therapists.

Participation would involve one in-person interview, guided by a series of questions I have developed in consultation with my advisor, which should take no more than an hour. Such interviews can be an occasion to reflect on and share from one's experience in this work. I look forward to sharing a copy of my completed dissertation with you (with gratitude!), which will include a review of relevant research studies, the thematic findings across these interviews, and a full reference list.

We hope this study will be a meaningful contribution in the area of therapist development. I would be honored if you would share of your valuable time and experience.

I will be following up soon by email to learn if you are willing and able to participate. In the meantime, please feel free to contact me at quan0065@umn.edu or [telephone number] with any questions or concerns.

Thank you for your consideration!

Sincerely,

Jo Quanbeck, M.A.
Doctoral Candidate
Counseling & Student Personnel Psychology
University of Minnesota

Tom Skovholt, Ph.D., LP, ABPP
Professor
Counseling & Student Personnel Psychology
University of Minnesota

Appendix C: Email Follow-Up to Prospective Participants

Dear XXXX:

I am a doctoral candidate in counseling psychology through the CSPP program at the University of Minnesota and am an advisee of Tom Skovholt, Ph.D., LP.

I hope you recently received my letter of invitation to participate in my qualitative dissertation study. (I'm attaching that letter here, in case you've not yet had a chance to consider this!)
I would be a privilege to sit down with you for an interview and hear from your experience, as a psychologist, of working with client concerns of grief and loss over time in the profession.

I would appreciate hearing from you as to your willingness to participate or to learn more about the study. I can be reached at quan0065@umn.edu or [telephone number].

Thank you for your consideration!

Jo

Jo Quanbeck, M.A.
Doctoral Candidate, Counseling Psychology (CSPP)
University of Minnesota

Appendix D: Email Follow-Up to Prospective Participants

Dear XXXX:

Thank you for your willingness to participate in my qualitative dissertation study by taking part in an interview! I'm grateful you'll share of your time and rich experience in this way.
I'm attaching here a brief consent statement that shares a bit more about participation in the study, which we will also talk about in person when we meet. Briefly, however, a bit more introduction here:

Through interviews, my study will explore psychologists' experience of time and again encountering grieving clients. Specifically, this study investigates *how experienced psychologists have been impacted by recurrent close proximity to client's experiences of grief and loss; how they time and again open themselves to and engage this affective work; and how they maintain vitality while doing so.*

From your years of clinical experience, you know how often issues of loss and grief are central to client concerns. The open-ended interview questions will invite you to reflect on your experience of this area of your work with clients.

I am asking to schedule an hour-long conversational interview with you at your office, if that location works for you. If you would, please send a list of two or three times that might work for you in the coming weeks—and also confirm your office location.

It will be a privilege to talk with you. I look forward to it.

Jo

Jo Quanbeck, M.A.
Doctoral Candidate, Counseling Psychology (CSPP)
University of Minnesota
Phone: xxx
E-Mail: quan0065@umn.edu

Appendix E: Demographic Survey

DEMOGRAPHIC SURVEY
Research Project Title:

Encountering client grief: A phenomenological study of experienced psychologists.

1. What is your gender?
   - ☐ Male
   - ☐ Female
   - ☐ Self-identify (Please specify) _____

2. What is your age?
   - ☐ 21-30 years old
   - ☐ 31-40 years old
   - ☐ 41-50 years old
   - ☐ 51-60 years old
   - ☐ 61-70 years old
   - ☐ >70 years old

3. What of the following describes you? (Check all that apply.)
   - ☐ American Indian / Alaska Native
   - ☐ Asian / Pacific Islander
   - ☐ Black / African American
   - ☐ Hispanic / Latino(a)
   - ☐ White / Caucasian
   - ☐ Another racial or ethnic group (please specify) _____

4. What is the highest academic degree that you completed? _____

5. How many years have you been a licensed psychologist?
   - ☐ < 5 years
   - ☐ 6-10 years
   - ☐ 11-15 years
   - ☐ 16-20 years
   - ☐ 21-25 years
   - ☐ > 25 years

6. In what type of setting do you currently practice? Check all that apply. (If not currently practicing, what was your most recent professional setting?)

   - ☐ University Counseling Center
   - ☐ Private Practice
   - ☐ Community Clinic (Outpatient or Day Treatment)
   - ☐ Inpatient/Hospital
   - ☐ Other (Please specify) _____

7. What are your primary roles as a psychologist at this time? Please indicate full-time or part-time in the space provided.

☐ Therapist/Practitioner _____
☐ Academic (Professor/Instructor) _____
☐ Supervisor / Training Provider _____
☐ Consultant _____
☐ Psychological Assessment _____
☐ Other (please specify) _____

8. On average, how many hours do you directly work with clients per week at this time?

☐ 0-10 hours
☐ 11-20 hours
☐ 21-30 hours
☐ 31-40 hours
☐ greater than 40 hours

Appendix F: Interview Protocol

Introduction: Therapists often work with clients who are experiencing significant personal loss. I'm interested in the therapist's experience of encountering grieving clients, over time in the profession. In the course of your years as a clinician, I'm sure you have worked with many clients for whom grief has been a central concern. This conversation orients you to this particular dimension of your work as a therapist and invites you to reflect on your experience.

Questions:

1. As you reflect on your work over time, please describe your own experience of sitting with grieving clients.
2. As you reflect on your work over time, what comes to mind about what you have you learned through working with grieving clients?
3. If your experience working closely with clients experiencing grief has shifted or changed over time, what has informed that change for you?
4. What is it about you that allows you to time and again enter into and open yourself to this area of relational work?
5. This human experience of grief can at times be accompanied by significant emotion or affect. What has been your experience when present with clients experiencing grief?
6. What is important for you in terms of maintaining professional vitality when working with clients experiencing grief?
7. What has challenged your ability to remain vibrant in this work over time?
8. I invite you to consider whether there are aspects of your own personal identity that impact your experience of working with clients around grief. If any come to mind, please describe these.
9. I invite you to consider whether there are aspects of your own professional identity that impact your experience of working with clients around grief. If any come to mind, please describe these.
10. I'd invite you to think about defining moments in terms of your work with clients around issues of grief. If a particular experience came to mind that has been influential for you—has had lasting significance for you—please describe this.
11. Having reflected on this topic throughout this conversation, is there anything you would like to add?